LEGISLATIVE AND PUBLIC POLICY COMMITTEE (LPPC)
MEETING NOTICE/AGENDA

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State Council Office
1507 21st Street, Suite 210
Sacramento, CA 95811
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February 17, 2011
10:30 a.m. – 4:00 p.m.

Pursuant to Government Code Sections 11123.1 and 11125(f), individuals with disabilities who require accessible alternative formats of the agenda and related meeting materials and/or auxiliary aids/services to participate in the meeting, should contact Michael Brett at (916) 322-8481 or michael.brett@scdd.ca.gov by 5:00 pm, February 10, 2011.

**Denotes action item.*

		Page
1. **CALL TO ORDER**	R. Ceragioli	
2. **ESTABLISHMENT OF QUORUM**	R. Ceragioli	
3. **INTRODUCTIONS AND ANNOUNCEMENT**	R. Ceragioli	
4. ***APPROVAL OF 1/27/11 MINUTES**	R. Ceragioli	4

5. **PUBLIC COMMENTS**

*This item is for members of the public only to provide comments and/or present information to the Council on matters **not** on the agenda. Each person will be afforded up to three minutes to speak. Written requests, if any, will be considered first. The Council will provide a public comment period, not to exceed a total of seven minutes, for public comment prior to action on each agenda item.*

6. **LEGISLATIVE UPDATES**

A. State Legislation

(i) * Assembly Bill 171	C. Arroyo	16
(ii) * Assembly Bill 170	M. Corral	30
(iii) * Assembly Bill 39	C. Arroyo	33
(iv) * Assembly Bill 181	M. Corral	44
(v) * Senate Bill 121	C. Arroyo	49
(vi) * Assembly Bill 154	M. Corral	63
(vii) Council Legislative Update	C. Arroyo	

B. 2011-12 State Budget — C. Risley

(i) * Budget Trailer Bills		83
(ii) Budget Update		

C. Federal Legislation

(i) Individual Transition Plan	K. Alipourfard	377

D. Executive Committee Action on LPPC Items — R. Ceragioli

E. Area Board Legislative Updates — R. Smith — 426

7. **POLICY ISSUES**

A. *Public Benefits Policy Paper	C. Arroyo	427
B. *Special Education Policy Paper	J. Aguilar	

8. **INFORMATION ITEMS**	C. Arroyo	
A. Assembly Bill 254		449
9. **ADJOURNMENT**	R. Ceragioli	

DRAFT

Legislative & Public Policy (LPPC) Committee Minutes
Thursday, January 27, 2011

Members Present	Members Absent
Jorge Aguilar, Chairperson	Marilyn Barraza
Jennifer Allen	Denise Filz
Tho Vinh Banh	Robin Hansen
Ray Ceragioli	David Mulvaney
Lisa Cooley	Michael Rosenberg
Connie Lapin	Margaret Shipp
Leroy Shipp	
Rocio Smith	**Others Present**
	Karim Alipourfard
	Christofer Arroyo
	Michael Brett
	Carol Risley

1. CALL TO ORDER

Jorge Aguilar, Chairperson, called the meeting to order at 10:35 AM.

2. ESTABLISHMENT OF A QUORUM

A quorum was established.

3. INTRODUCTIONS AND ANNOUNCEMENTS

Members introduced themselves and announcements were made.

4. APPROVAL OF 10/5/10 MEETING MINUTES PUBLIC COMMENTS

It was moved, seconded (Smith/Lapin), and carried to approve the October 15, 2010 minutes as presented. (1 abstention)

5. PUBLIC COMMENTS

No comments were provided from the public.

6. LEGISLATIVE UPDATES

A. Council Action on LPPC Recommendations- A summary of Council actions on LPPC recommendations (H.R. 1255 and comments on federal regulations) was presented and discussed.

B. Area Board Legislative Updates- Area Board legislative activities were reviewed and discussed including handouts that were distributed that demonstrated the cumulative impact of past budget reductions.

C. State Legislation- Chris Arroyo reviewed the Council's Legislative Update. The following bills were identified for analyses and presentation to the Committee for potential action: AB 39, 154, 170, 171, 181, and SB 121.

D. Federal Legislation

i. Reauthorization of the Federal DD Act- Karim Alipourfard reported on the federal Developmental Disabilities Assistance and Bill of Rights Act Reauthorization. NACDD, along with others, has been working on the potential requthorization issues and language and that information was reviewed by the Committee. Following discussion, it was moved, seconded (Ceragioli/Cooley), and carried that the Council continue to track and participate in NACDD's discussions on this matter and to provide written input addressing the proposed language, specifically the concerning the merits of bringing the State developmental disabilities agencies into the federal law as a partner. Copies of correspondence in this regard would be sent to the California federal partners.

ii. Reauthorization of the Individuals with Disabilities Education Act (IDEA) - Karim Alipourfard presented background materials on IDEA and the lack of any specific proposals for reauthorization at this time. The Committee discussed the future IDEA reauthorization and agreed the Council should provide comments as part of a larger coalition. Discussion ensued and consensus was achieved that a refocused Special Education Stakeholder Workgroup would meet as soon as resources permit to focus on the IDEA reauthorization.

E. 2011-12 Governor's Budget- Carol Risley presented key elements in the Governor's 2011-12 Budget proposal that would impact people with developmental disabilities along with staff recommendations for action. Following extensive discussion/debate, it was moved, seconded, (Shipp/Lapin) and carried to adopt the staff recommendations, as amended and attached to these minutes, for recommendation for action by the Council Executive Committee. Clarification was provided that testimony consistent with LPPC's actions would be presented as LPPC positions at upcoming budget hearings pending action by the Executive committee.

F. Area Board 9 Legislative Advocacy Booklet and DVD- LPPC was presented a legislative advocacy booklet and accompanying DVD developed by Area Board 9.

G. Capitol Action Day- Chris Arroyo presented background information on the Disability Capitol Action Day, which falls on May 25, 2011. It was moved, seconded (Ceragioli/Lapin), and carried that the Council present information to legislators on Capitol Action Day pertaining to the budget's May revise, the Council's approved policy papers, the Governor's Briefing Paper, and bills for which the Council has taken a position.

7. POLICY ISSUES

Both the Public Benefits and Special Education policy papers were briefly discussed. It was agreed to continue discussion at the next LPPC meeting.

8. CALENDAR OF COMMITTEE MEETINGS

The LPPC agreed to meet monthly, on the third Thursday of every month, except July, November, and December.

9. ADJOURNMENT

The meeting was adjourned at 3:53 PM.

Legislative and Public Policy Committee (LPPC)
2011-12 Governor's Budget

Actions and Recommendations for Executive Committee Action

Basic Principles

LPPC recommends that prior to adopting positions on individual budget proposals that the Executive Committee act on a set of basic principles as follows:

- *The Council recognizes the magnitude of California's fiscal crisis and that all Californians will be impacted by balancing the budget, thus individuals with developmental disabilities must share in this correction, but should not be expected to assume an inequitable portion of the burden.*

- *While budget proposals may define and refine the level of entitlement to services and supports in the developmental services system, they must not eliminate the entitlement to access, and to be served by the system for eligible individuals and families.*

- *Budget proposals must not result in people with developmental disabilities having their health and safety negatively impacted, jeopardize their inclusion in the community, force them to become less productive, and/or reduce their ability to direct their own lives and make choices.*

- *Budget proposals must not violate the basic tenet of the developmental services system as a civil/social rights model rather than medical model, nor reduce the quality of available services.*

- *Budget proposals must examine the entire system to seek administrative efficiencies and economies of scale, not just impact direct services.*

- *Budget proposals must not violate the basic underpinnings of existing federal and state statutes and court decisions that serve to assure the*

provision of quality services and supports and protect basic human rights of individuals with developmental disabilities.

Department of Developmental Services (DDS)

► *Any budget reductions must be shared by the entire developmental services system, not solely applied to community services, and more specifically purchase of services and supports for individuals with developmental disabilities.*

Community Services Program

- Proposed $149.7 million increase in Purchase of Services (POS) and Prevention Program due to increased caseload and utilization.

  ► *Support*

- $0.5 million decrease due to the delayed implementation of the Self-Directed Services.

  ► *Support, although the Council is extremely frustrated with the continued delay with implementing this option in California.*

- $13.0 million increase in regional center operations costs primarily due to caseload increases and additional Home and Community-Based Services (HCBS) waiver enrollments.

  ► *Support*

- Increase of $134.1 million in General Fund and corresponding decrease in reimbursements due to the end of federal stimulus funding.

  ► *Support*

8

- Continuation of the 4.25 percent payment reduction in 2011-12. The reduction impacts both regional center operations and POS for a total decrease of $165.5 million ($91.5 million General Fund). There is an incremental decrease from 2010-11 of $2.8 million due to the reduced total funding level in 2011-12.

  ► *Request proposal be reduced to 3% to mitigate the overall impact reduction has had on the availability and quality of services particularly when taking into consideration the cumulative effect of historic rate freezes and other reductions in services and supports over the past five years. See attached chart illustrating this cumulative effect.*

- Continue reimbursement funding from the California Children and Families Commission (Proposition 10) in 2011-12, resulting in a General Fund savings of $50 million.

  ► *Support*

- $27.2 million decrease in 2011-12, as the 2010-11 budget included costs associated with retroactive processing of claims for 2007-08 through 2010-11 (four years) that is not required in the budget year. These costs related to increasing Federal Financial Participation (FFP) for day treatment and transportation costs for residents of Intermediate Care Facilities for individuals with developmental disabilities (ICF-DD). The 2011-12 budget retains $9.5 million for budget year claims.

  ► *Support*

- $1.7 million increase to establish Financial Management Services (FMS) as an option for vouchered respite, transportation, and day care services consistent with federal requirements to renew the HCBS waiver.

  ► *Request additional explanation as to whom or what will provide these services, how $1.7 million be used and what are consumer/family protections related to this service.*

- $70.1 million increase to reflect the impact of service reductions proposals in Medi-Cal and SSI/SSP programs that will increase regional centers POS costs in 2011-12.

  ► *Support and request similar provision for individuals with developmental disabilities who will experience a decrease in needed In-Home Supportive Services (IHSS).*

- Increased accountability and transparency and system-wide cost containment measures to generate significant General Fund savings necessary to achieve the balance of overall required reduction of $750 million.

  ► *Support of increased accountability and transparency.*

  ► *Request that prior to direct service limitations/reductions, DDS identify areas for increased administrative efficiencies and economies of scale within the system infrastructure.*

  ► *While not supportive of service and support reductions to individuals with developmental disabilities and their families, the Council recognizes the system will share in the budget burden and any proposals put forth must include a input from the impacted parties, particularly the underserved and people of color, and accurate analysis of the potential impact on the continued ability of persons to increase or retain their independence, productivity, self-direction and inclusion.*

Developmental Centers

- The Department will pursue additional federal funds for treatment services provided to individuals residing in the secure facility at Porterville Developmental Center. It is anticipated this will result in General Fund savings of $10 million in 2011-12.

  ► *Support*

- The capital outlay budget includes $2.0 million General Fund to design and install automatic fire sprinklers in 13 buildings that house Nursing Facility and General Acute Care consumers at the Fairview, Porterville and Sonoma Developmental Centers.

  ► *Support*

- Budget proposes the reappropriation of funding for an addressable fire alarm system, already approved by the Legislature, in consumer utilized buildings at Fairview Developmental Center. This project continues to be a critical safety improvement, licensing and code compliance need for Fairview's consumers, staff, and visitors.

  ► *Support*

- "…construction phase for a new piping system, already approved by the Legislature, to supply additional oxygen, medical air and suction, and a new oxygen storage tank at the Johnson/Ordahl building at Sonoma Developmental Center.

  ► *Support*

DEPARTMENT OF SOCIAL SERVICES (CDSS)

Supplemental Security Income/State supplementary Payment (SSI/SSP)

- The Governor's Budget proposal would reduce monthly SSP grants for individuals to the federally required minimum payment standard. Under this proposal, the maximum monthly SSI/SSP cash grant for individuals would be reduced by $15 per month (from $845 to $830), beginning June 1, 2011. SSP grants for couples were previously reduced to the federal minimum in November 2009.

  ► *Oppose. This decrease will negatively impact the ability of persons to live in the community. While individuals with developmental disabilities, served by the regional center system, will have their reduction backfilled (see proposal under DDS), others on SSI/SSP will not.*

//

In-Home Supportive Services (IHSS)

- Budget proposed an 8.4percent reduction to assessed hours for all IHSS recipients for General Fund savings of $127.5 million in 2011-12. This proposal, combined with the 3.6percent reduction enacted in 2010-11, would bring the total across-the-board reduction in assessed hours for IHSS recipients to 12 percent.

  ► *Oppose increase of 8.4 % across-the-board reduction and substitute an individualized review and, if appropriate, reduction in assessed hours.*

- Proposal would eliminate domestic and related services (which include housework, shopping for food, meal preparation and cleanup, and laundry) for consumers living with their provider. IHSS applicants/recipients who have a need for domestic and/or related services that cannot be met in common due to a medically verified condition of other members of the shared living arrangement could be authorized hours for any of these services that meet the need assessment metrics. Minor recipients are living with their parent(s), the need is being met in common; hence, the need for domestic and related service hours would no longer be allowed. The parent would be presumed available to perform these tasks unless the parent could provide medical verification of his/her inability to do so.

  ► *Oppose*

- Requires the provision of IHSS services to be conditioned upon a physician's written certification that personal care services are necessary to prevent out-of-home care.

  ► *Oppose. IHSS is not a medical model program and physicians are not trained to assess a person's ability to live in the community. Continued certification of need for services should be completed by an entity that is qualified and uses a standardized assessment tool and process throughout California.*

DEPARTMENT OF AGING (CDA)

- Multipurpose Senior Centers (MSSP) provide case management services for elderly clients who qualify for placement in a nursing facility but who wish to remain in the community. This proposal would eliminate these services for a savings of $19.9 million General Fund in 2011-12.

  ► Oppose. *Closure of MSSP sites are designed to keep people included in communities and such inclusion is less costly to the taxpayers that placement in skilled nursing facilities.*

DEPARTMENT OF HEALTH CARE SERVICES (DHCS)

► *All efforts must be made to access and maximize other sources of income including but not limited to:*

- *Issuing directions to counties regarding the use of state and local funds for Medi-Cal share of costs for California Children's Services (CCS).*
- *Require that the Consolidated Omnibus Budget Reconciliation Act (COBRA) notices be issued in California to provide information about the Health Insurance Premium Payment Program (HIPP) for coverage of premium costs of COBRA benefits; and information that receiving an extension of the 11-month disability extension does not require a person to quality for Social Security benefits.*
- *Examine other states' successes in ensuring that costs of long-term care are not prematurely shifted from Medicare to Medi-Cal.*
- *Seek payments by health plans to cover their obligations to children with disabilities covered under their parent's group plans.*
- *Require private insurance plans to cover the full cost of wheelchairs and other durable medical equipment.*
- *Actively promote the coverage of children under 26 years old on their parent's private insurance.*

- *Pursue federal financial participation for the costs of veterans pharmacy benefits.*

Medi-Cal

- Proposal establishes utilization controls at a maximum annual benefit dollar on hearing aids ($1,510), durable medical equipment ($1,604), incontinence supplies ($1,659), urological supplies ($6,435), and wound care ($391), limits prescriptions (except life-saving drugs) to six per month, and limits the number of doctor visits to ten per year.

  ▶ *Oppose. Decisions about the level of medical services required should be made on an individualized basis. The potential impact of a formula could be to jeopardize the health and safety of individuals with developmental disabilities.*

- Co-payments would become mandatory. This proposal includes a $5 co-payment on physician, clinic, dental, and pharmacy services ($3 on lower cost preferred drugs) for savings of $294.4 million in 2011-12.

  ▶ *Oppose. However if adopted, request a process be established to grant exceptions from the increased level or entire co-pay requirement if the co-pay will reduce access to necessary medical care services. With the decrease in SSI/SSP, less cash is available to people who access both publically funded supports, thus the impact of coupling these proposals is results in a disproportionate reduction to this population as compared to other publically funded services.*

- Budget proposal would also eliminate the optional Adult Day Health Care program for savings of $1.5 million in 2010-11 and $176.6 million in 2011-12.

  ▶ *Oppose. This will impact people with developmental disabilities and their ability to remain included in their communities. It also shifts the burden to the Department of Developmental Services for meeting these people's needs without any fiscal relief to DDS.*

- Budget proposes to reduce provider payments by 10 percent for physicians, pharmacy, clinics, medical transportation, home health, Adult Day Health Care, certain hospitals, and nursing facilities.

  ▶ *To the extent that this would reduce the availability of medical care to persons with developmental disabilities, the proposal would add to the disproportionate share of reductions they would experience.*

- The Budget proposes to use $1 billion in Proposition 10 funds to fund Medi-Cal services for children through age five.

  ▶ *Support*

- The Budget proposes to extend the fee through June 31, 2011, which will save $160 million in Medical. Fee revenue is used to leverage federal funding to provide supplemental payments to hospitals for the provision of Medi-Cal services and to offset General Fund costs to a lesser degree.

  ▶ *Support*

LEGISLATIVE AGENDA ITEM DETAIL SHEET

Bill NUMBER/ISSUE: Assembly Bill (AB) 171, autism spectrum disorder

BILL SUMMARY: This bill requires health care service plans and health insurers to provide coverage for the screening, diagnosis, and treatment of autism spectrum disorders. It prohibits coverage from being denied solely on the basis of a diagnosis of an autism spectrum disorder. This bill also indicates that its provisions do not reduce any obligation to provide services to enrollees under individualized program plans, individualized family service plan, prevention program plans, individualized education programs, or individual service plans. Lastly, this bill explicitly does not require its provisions to be provided through the California Health Benefit Exchange that exceed the essential health benefits required under federal law.

BACKGROUND: Although a medical issue, it has been reported by many families that private insurers will not cover services associated with their child's diagnosis of autism or autism spectrum disorders. This includes a service known as applied behavioral analysis (ABA), which research has determined to be effective in the treatment of autism and autism spectrum disorders. AB 171 is sponsored by the Alliance of California Autism of Organizations. A similar bill was introduced last session, SB 1282.

ANALYSIS/DISCUSSION: If this bill passes, it may enable many families with children with autism or autism spectrum disorders to receive the treatment they need through their insurance providers without engaging in costly appeals or litigation. Additionally, it may make such treatment more readily available than by obtaining it through schools and/or regional centers.

Because the provisions of this bill that exceed essential health benefits under federal law through the California Health Benefit Exchange, a two tier system may be created.

COUNCIL STRATEGIC PLAN OBJECTIVE: Shape public policy that positively impacts Californians with developmental disabilities and their families.

PRIOR COUNCIL ACTIVITY: A similar bill, SB 1282 (Steinberg), was introduced last session and died in committee. The Council did not take a position before the bill died.

RECOMMENDATION(S): It is recommended that the Council support AB 171.

ATTACHMENT(S): AB 171 and the former SB 1282.

PREPARED: Christofer Arroyo, January 31, 2011

ASSEMBLY BILL No. 171

Introduced by Assembly Member Beall

January 20, 2011

An act to add Section 1374.73 to the Health and Safety Code, and to add Section 10144.51 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 171, as introduced, Beall. Autism spectrum disorder.

(1) Existing law provides for licensing and regulation of health care service plans by the Department of Managed Health Care. A willful violation of these provisions is a crime. Existing law provides for licensing and regulation of health insurers by the Insurance Commissioner. Existing law requires health care service plan contracts and health insurance policies to provide benefits for specified conditions, including certain mental health conditions.

This bill would require health care service plan contracts and health insurance policies to provide coverage for the screening, diagnosis, and treatment of autism spectrum disorders. The bill would, however, provide that no benefits are required to be provided by a health benefit plan offered through the California Health Benefit Exchange that exceed the essential health benefits required under federal law. The bill would prohibit coverage from being denied for specified reasons. Because the bill would change the definition of a crime with respect to health care service plans, it would thereby impose a state-mandated local program.

(2) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1374.73 is added to the Health and Safety Code, to read:

1374.73. (a) Every health care service plan contract issued, amended, or renewed on or after January 1, 2012, that provides hospital, medical, or surgical coverage shall provide coverage for the screening, diagnosis, and treatment of autism spectrum disorders. A health care service plan shall not terminate coverage, or refuse to deliver, execute, issue, amend, adjust, or renew coverage, to an enrollee solely because the individual is diagnosed with, or has received treatment for, an autism spectrum disorder.

(b) Coverage required to be provided under this section shall extend to all medically necessary services and shall not be subject to any limits regarding age, number of visits, or dollar amounts. Coverage required to be provided under this section shall not be subject to provisions relating to lifetime maximums, deductibles, copayments, or coinsurance or other terms and conditions that are less favorable to an enrollee than lifetime maximums, deductibles, copayments, or coinsurance or other terms and conditions that apply to physical illness generally under the plan contract.

(c) Coverage required to be provided under this section is a health care service and a covered health care benefit for purposes of this chapter. Coverage shall not be denied on the basis that the treatment is habilitative, nonrestorative, educational, academic, or custodial in nature.

(d) A health care service plan may request, no more than once annually, a review of treatment provided to an enrollee for autism spectrum disorders. The cost of obtaining the review shall be borne by the plan. This subdivision does not apply to inpatient services.

(e) A health care service plan shall establish and maintain an adequate network of qualified autism service providers with appropriate training and experience in autism spectrum disorders to ensure that enrollees have a choice of providers, and have timely access, continuity of care, and ready referral to all services required

to be provided by this section consistent with Sections 1367 and 1367.03 and the regulations adopted pursuant thereto.

(f) (1) This section shall not be construed as reducing any obligation to provide services to an enrollee under an individualized family service plan, an individualized program plan, a prevention program plan, an individualized education program, or an individualized service plan.

(2) This section shall not be construed as limiting benefits that are otherwise available to an enrollee under a health care service plan.

(3) This section shall not be construed as affecting litigation that is pending on January 1, 2012.

(g) On and after January 1, 2014, to the extent that this section requires health benefits to be provided that exceed the essential health benefits required to be provided under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) by qualified health plans offering those benefits in the California Health Benefit Exchange pursuant to Title 22 (commencing with Section 100500) of the Government Code, the specific benefits that exceed the federally required essential health benefits are not required to be provided when offered by a health care service plan contract through the Exchange. However, those specific benefits are required to be provided if offered by a health care service plan contract outside of the Exchange.

(h) As used in this section, the following terms shall have the following meanings:

(1) "Autism spectrum disorder" means a neurobiological condition that includes autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified.

(2) "Behavioral health treatment" means professional services and treatment programs, including behavioral intervention therapy, applied behavioral analysis, and other intensive behavioral programs, that have demonstrated efficacy to develop, maintain, or restore, to the maximum extent practicable, the functioning or quality of life of an individual and that have been demonstrated to treat the core symptoms associated with autism spectrum disorder.

(3) "Behavioral intervention therapy" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in behaviors, including the use of direct observation, measurement, and functional analyses of the relationship between environment and behavior.

(4) "Diagnosis of autism spectrum disorders" means medically necessary assessment, evaluations, or tests to diagnose whether an individual has one of the autism spectrum disorders.

(5) "Evidence-based research" means research that applies rigorous, systematic, and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.

(6) "Pharmacy care" means medications prescribed by a licensed physician and surgeon or other appropriately licensed or certified provider and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

(7) "Psychiatric care" means direct or consultative psychiatric services provided by a psychiatrist or any other appropriately licensed or certified provider.

(8) "Psychological care" means direct or consultative psychological services provided by a psychologist or any other appropriately licensed or certified provider.

(9) "Therapeutic care" means services provided by licensed or certified speech therapists, occupational therapists, or physical therapists or any other appropriately licensed or certified provider.

(10) "Treatment for autism spectrum disorders" means all of the following care, including necessary equipment, prescribed or ordered for an individual diagnosed with one of the autism spectrum disorders by a licensed physician and surgeon or a licensed psychologist or any other appropriately licensed or certified provider who determines the care to be medically necessary:

(A) Behavioral health treatment.

(B) Pharmacy care.

(C) Psychiatric care.

(D) Psychological care.

(E) Therapeutic care.

(F) Any care for individuals with autism spectrum disorders that is demonstrated, based upon best practices or evidence-based research, to be medically necessary.

SEC. 2. Section 10144.51 is added to the Insurance Code, to read:

10144.51. (a) Every health insurance policy issued, amended, or renewed on or after January 1, 2012, that provides hospital, medical, or surgical coverage shall provide coverage for the screening, diagnosis, and treatment of autism spectrum disorders. A health insurer shall not terminate coverage, or refuse to deliver, execute, issue, amend, adjust, or renew coverage, to an insured solely because the individual is diagnosed with, or has received treatment for, an autism spectrum disorder.

(b) Coverage required to be provided under this section shall extend to all medically necessary services and shall not be subject to any limits regarding age, number of visits, or dollar amounts. Coverage required to be provided under this section shall not be subject to provisions relating to lifetime maximums, deductibles, copayments, or coinsurance or other terms and conditions that are less favorable to an insured than lifetime maximums, deductibles, copayments, or coinsurance or other terms and conditions that apply to physical illness generally under the policy.

(c) Coverage required to be provided under this section is a health care service and a covered health care benefit for purposes of this part. Coverage shall not be denied on the basis that the treatment is habilitative, nonrestorative, educational, academic, or custodial in nature.

(d) A health insurer may request, no more than once annually, a review of treatment provided to an insured for autism spectrum disorders. The cost of obtaining the review shall be borne by the insurer. This subdivision does not apply to inpatient services.

(e) A health insurer shall establish and maintain an adequate network of qualified autism service providers with appropriate training and experience in autism spectrum disorders to ensure that insureds have a choice of providers, and have timely access, continuity of care, and ready referral to all services required to be provided by this section consistent with Sections 10133.5 and 10133.55 and the regulations adopted pursuant thereto.

(f) (1) This section shall not be construed as reducing any obligation to provide services to an insured under an individualized family service plan, an individualized program plan, a prevention program plan, an individualized education program, or an individualized service plan.

(2) This section shall not be construed as limiting benefits that are otherwise available to an enrollee under a health insurance policy.

(3) This section shall not be construed as affecting litigation that is pending on January 1, 2012.

(g) On and after January 1, 2014, to the extent that this section requires health benefits to be provided that exceed the essential health benefits required to be provided under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) by qualified health plans offering those benefits in the California Health Benefit Exchange pursuant to Title 22 (commencing with Section 100500) of the Government Code, the specific benefits that exceed the federally required essential health benefits are not required to be provided when offered by a health insurance policy through the Exchange. However, those specific benefits are required to be provided if offered by a health insurance policy outside of the Exchange.

(h) As used in this section, the following terms shall have the following meanings:

(1) "Autism spectrum disorder" means a neurobiological condition that includes autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified.

(2) "Behavioral health treatment" means professional services and treatment programs, including behavioral intervention therapy, applied behavioral analysis, and other intensive behavioral programs, that have demonstrated efficacy to develop, maintain, or restore, to the maximum extent practicable, the functioning or quality of life of an individual and that have been demonstrated to treat the core symptoms associated with autism spectrum disorder.

(3) "Behavioral intervention therapy" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in behaviors, including the use of direct observation, measurement, and functional analyses of the relationship between environment and behavior.

(4) "Diagnosis of autism spectrum disorders" means medically necessary assessment, evaluations, or tests to diagnose whether an individual has one of the autism spectrum disorders.

(5) "Evidence-based research" means research that applies rigorous, systematic, and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.

(6) "Pharmacy care" means medications prescribed by a licensed physician and surgeon or other appropriately licensed or certified provider and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

(7) "Psychiatric care" means direct or consultative psychiatric services provided by a psychiatrist or any other appropriately licensed or certified provider.

(8) "Psychological care" means direct or consultative psychological services provided by a psychologist or any other appropriately licensed or certified provider.

(9) "Therapeutic care" means services provided by licensed or certified speech therapists, occupational therapists, or physical therapists or any other appropriately licensed or certified provider.

(10) "Treatment for autism spectrum disorders" means all of the following care, including necessary equipment, prescribed or ordered for an individual diagnosed with one of the autism spectrum disorders by a licensed physician and surgeon or a licensed psychologist or any other appropriately licensed or certified provider who determines the care to be medically necessary:

(A) Behavioral health treatment.

(B) Pharmacy care.

(C) Psychiatric care.

(D) Psychological care.

(E) Therapeutic care.

(F) Any care for individuals with autism spectrum disorders that is demonstrated, based upon best practices or evidence-based research, to be medically necessary.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of

the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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AMENDED IN ASSEMBLY JUNE 24, 2010

AMENDED IN SENATE MAY 26, 2010

AMENDED IN SENATE APRIL 28, 2010

AMENDED IN SENATE MARCH 23, 2010

SENATE BILL **No. 1282**

Introduced by Senator Steinberg

February 19, 2010

~~An act to add and repeal Chapter 5.2 (commencing with Section 2529.50) of Division 2 of the Business and Professions Code, relating to healing arts.~~ *An act relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

SB 1282, as amended, Steinberg. ~~Applied behavior analysis.~~ *Health care coverage.*

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, including, but not limited to, pervasive developmental disorder or autism, under the same terms and conditions applied to other medical conditions, as specified.

This bill would state the intent of the Legislature to enact legislation to provide clarification on the duties imposed upon health care service plans and health insurers to inform consumers about the coverage provided for the diagnosis and treatment of autism and pervasive developmental disorders under the existing mental health parity law.

~~Existing law provides for the licensure and regulation of various healing arts practitioners, including, but not limited to, marriage and family therapists, clinical social workers, educational psychologists, and professional clinical counselors, by the Board of Behavioral Sciences in the Department of Consumer Affairs.~~

~~This bill would, until January 1, 2017, make it an unfair business practice for a person to use certain titles or other terms implying that he or she is certified as an applied behavior analyst unless he or she holds a current certification from a specified organization, or to state, advertise, or represent that he or she is certified or licensed by a governmental agency as an applied behavior analyst. The bill would make its provisions subject to review by the Joint Committee on Boards, Commissions, and Consumer Protection.~~

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. It is the intent of the Legislature to enact legislation to provide clarification on the duties imposed upon health care service plans and health insurers to inform consumers about the coverage provided for the diagnosis and treatment of autism and pervasive developmental disorders under the existing mental health parity law.

~~SECTION 1. It is the intent of the Legislature in enacting this act to provide state recognition of educated, trained, and experienced individuals that provide applied behavior analysis to individuals with medical conditions such as autism spectrum disorder and other conditions that are responsive to applied behavior analysis.~~

~~SEC. 2. Chapter 5.2 (commencing with Section 2529.50) is added to Division 2 of the Business and Professions Code, to read:~~

~~CHAPTER 5.2. APPLIED BEHAVIOR ANALYSIS~~

~~2529.50. For purposes of this chapter, "applied behavior analyst" means a person who provides applied behavior analysis.~~

~~2529.51. (a) For purposes of this chapter, "applied behavior analysis" means any of the following functions:~~

~~(1) Designing, implementing, and evaluating systematic instructional and environmental modifications to produce social improvements in the behavior of individuals or groups.~~

~~(2) Applying the principles, methods, and procedures of behavior analysis.~~

~~(3) Utilizing contextual factors and establishing operations, antecedent stimuli, positive reinforcement, other consequences, and other behavior analysis procedures to help people develop new behaviors, increase or decrease existing behaviors, and emit behaviors under specific environmental conditions.~~

~~(4) Assessing functional relations between behavior and environmental factors, known as functional assessment and functional analysis.~~

~~(5) Using procedures based on scientific research and the direct observation and measurement of behavior and environment.~~

~~(6) Determining whether a nonlicensed or noncertified individual shall be deemed as qualified to perform all of the functions under this subdivision, subject to his or her supervision.~~

~~(b) "Applied behavior analysis" does not include psychological testing, neuropsychology, psychotherapy, sex therapy, psychoanalysis, hypnotherapy, or long-term counseling.~~

~~(c) The definition in this section shall apply regardless of the source of payment or reimbursement.~~

~~2529.52. It is an unfair business practice for a person to state or advertise or put out any sign or card or other device, or to represent to the public through any print or electronic media, that he or she is certified, registered, or licensed by a governmental agency as an applied behavior analyst.~~

~~2529.53. It is an unfair business practice for any person to hold himself or herself out or to use the title of "certified applied behavior analyst" or any other term, such as "licensed," "registered," or "CABA," that implies or suggests that the person is certified as an applied behavior analyst without holding a current certification from a national organization that certifies applied behavior analysts and that is accredited by the National Commission on Certifying Agencies.~~

~~2529.54. The superior court in and for the county in which any person acts in violation of the provisions of this chapter, may, upon a petition by any person, issue an injunction or other appropriate order restraining the conduct. The proceedings under this paragraph~~

~~shall be governed by Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure.~~

~~2529.55. (a) Nothing in this chapter shall be construed to prevent applied behavior analysis providers who are vendorized by one of the California Regional Centers or hold state accredited nonpublic agency status from developing, providing, or supervising applied behavior analysis consistent with the requirements of their Regional Center vendorization or nonpublic agency certification or accreditation, provided their practice of applied behavior analysis is commensurate with their level of training and experience, and they do not hold themselves out to the public by any title or description stating or implying that they are Certified Behavior Analysts, that they are "certified" to practice applied behavior analysis if they are not in fact certified, or that they are recognized or certified by the state to practice applied behavior analysis.~~

~~(b) Nothing in this chapter shall be construed to require certification, licensure, recognition, or authorization to provide applied behavior analysis nor to add to or increase requirements for providing applied behavior analysis.~~

~~(c) Nothing in this chapter shall be construed to prevent a physician and surgeon, psychologist, clinical social worker, marriage and family therapist, speech-language pathologist, occupational therapist, physical therapist, or professional clinical counselor from providing applied behavior analysis when acting within the scope of his or her license, formal training, experience, and accepted standards of his or her profession.~~

~~2529.56. This chapter shall be subject to the review required by Division 1.2 (commencing with Section 473).~~

~~2529.57. This chapter shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.~~

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LEGISLATIVE AGENDA ITEM DETAIL SHEET

BILL NUMBER/ISSUE: Assembly Bill (AB) 170

BILL SUMMARY: T his bill seeks to enact legislation that would divide Inland Regional Center, which serves Riverside and San Bernardino counties, into two separate regional centers that independently serve their communities.

BACKGROUND: This bill does not include information regarding the reason for the split; however, it is most likely due to the recent investigation and surrounding issues of Inland Regional Center.

ANALYSIS/DISCUSSION: Currently, there is one regional center, Inland that serves the San Bernardino and Riverside areas and about 21,200 individuals in a 28,000 mile area. By comparison, Lanterman Regional Center serves approximately 7,000 individuals and Alta Regional Center serves approximately 17,000 individuals.

It is assumed that by dividing the regional center, more oversight and accountability can be provided to two smaller offices; however, this may not be the case. There has been no information provided regarding increased oversight. Also, the division may create significant increased overhead costs.

A more appropriate approach may be for a review of the entire regional center system in the southern California to determine how best to meet the needs of each community. In addition, emphasis should be directed on oversight and accountability without increasing overhead costs.

COUNCIL STRATEGIC PLAN OBJECTIVE: Shape public policy that positively impacts Californians with developmental disabilities and their families.

PRIOR COUNCIL ACTIVITY: None.

RECOMMENDATION(S): It is recommended that the Council take a watch position on this bill at this time.

ATTACHMENT(S): AB 170

PREPARED: Melissa C. Corral, January 31, 2011

ASSEMBLY BILL No. 170

Introduced by Assembly Member Jeffries

January 20, 2011

An act relating to developmental services.

LEGISLATIVE COUNSEL'S DIGEST

AB 170, as introduced, Jeffries. Developmental services: regional centers: Inland Regional Center.

Under existing law, the Lanterman Developmental Disabilities Services Act, the State Department of Developmental Services is authorized to contract with regional centers to provide support and services to individuals with developmental disabilities.

This bill would state the intent of the Legislature to enact legislation that would divide the Inland Regional Center, which serves Riverside and San Bernardino counties, into 2 separate regional centers that independently serve their respective communities.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. It is the intent of the Legislature to enact legislation that does all of the following:

(a) Rectifies the level of accountability and the quality of services provided to consumers of the regional center in Riverside and San Bernardino counties.

(b) Increases local involvement and ensures that consumers at the regional center in Riverside and San Bernardino counties are given the individual attention and service they deserve.

(c) Divides the Inland Regional Center, which serves the Riverside and San Bernardino counties, into two separate regional centers that independently serve their respective communities in order to address the concerns in subdivisions (a) and (b).

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LEGISLATIVE AGENDA ITEM DETAIL SHEET

Bill NUMBER/ISSUE: Assembly Bill (AB) 39 (Beall), special education: funding

BILL SUMMARY: This bill appropriates $57 million from the Mental Health Services Fund (which was established under Proposition 63) to give to the county mental health departments to pay for the provision of special education services. Proposition 63 requires that all funds in the Mental Health Services Fund are continuously appropriated – and this has not always occurred.

Additionally, this bill also creates a work group composed of county mental health directors and the Superintendant of Public Instruction to develop a transitional program to transfer responsibilities from the county mental health departments to the Department of Education in the provision of special education services pertaining to mental health.

BACKGROUND: Assembly Bill 3632, passed in 1984, created the procedures and funding structure to ensure that students in special education who need mental health services would receive them; however, the previous administration defunded this program – contrary to the Proposition 63 requirement – in its entirety ($133 million) thus eliminating it. Litigation is in process at the time of this writing.

The California Alliance of Child and Family Services are sponsoring this bill to ensure adequate funding of mental health services for students receiving special education services.

ANALYSIS/DISCUSSION: Many families and students have had difficulty or have been unable to obtain AB 3632 services. Moreover, it has been reported that many school districts have refused to implement AB 3632 services without adequate funding.

Although the AB 3632 program was defunded, it:

- did not release the Proposition 63 requirement to continuously fund programs; and,
- did not release the school districts of their obligation to provide students in special education with a free appropriate public education (FAPE) to meet their unique needs and prepare them for further education, independent living, and employment.

Without adequate funding in place, the educational system has substantial and legitimate difficulties in meeting its special education obligations and the required appropriations to the Mental Health Services Fund are not being met.

COUNCIL STRATEGIC PLAN OBJECTIVE: Shape public policy that positively impacts Californians with developmental disabilities and their families.

PRIOR COUNCIL ACTIVITY: None.

RECOMMENDATION(S): It is recommended that the Council support AB 39.

ATTACHMENT(S): AB 39 and AB 3632 Report developed by the Legislative Analyst Office in June 2010.

PREPARED: Christofer Arroyo, January 31, 2011

ASSEMBLY BILL No. 39

Introduced by Assembly Member Beall

December 6, 2010

An act relating to special education, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 39, as introduced, Beall. Special education: funding.

Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63, establishes the Mental Health Services Fund to fund specified county mental health programs. The act provides that all moneys in the Mental Health Services Fund are continuously appropriated to the State Department of Mental Health. The act may be amended only by a ⅔ vote of both houses of the Legislature and only so long as the amendment is consistent with and furthers the intent of the act.

This bill would require the department to allocate $57,000,000 of those moneys to county mental health departments for purposes of providing special education services, thereby making an appropriation. The bill also would require the Superintendent of Public Instruction and county mental health directors to jointly convene a technical working group to develop a transitional program to transfer the responsibilities associated with providing special education services from county mental health departments to the State Department of Education.

This bill would declare that it furthers the purposes of the Mental Health Services Act.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: ⅔. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. (a) From the moneys continuously appropriated from the Mental Health Services Fund pursuant to Section 5890 of the Welfare and Institutions Code, the State Department of Mental Health shall allocate the sum of fifty-seven million dollars ($57,000,000) to county mental health departments for purposes of providing special education services.

(b) The Superintendent of Public Instruction and county mental health directors shall jointly convene a technical working group to develop a transitional program to transfer the responsibilities associated with providing special education services from county mental health departments to the State Department of Education.

SEC. 2. The Legislature finds and declares that this act further the purposes of the Mental Health Services Act.

SEC. 3. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order for pupils to continue to receive all of the special education services they need at the earliest possible time, it is necessary for this act to take effect immediately.

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June 9, 2010

AB 3632 Mental Health Services

LEGISLATIVE ANALYST'S OFFICE

Presented to:
The Conference Committee on the Budget

LAO
65 YEARS OF SERVICE

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65 YEARS OF SERVICE

AB 3632 Background

☑ ***Congress Guaranteed Free Appropriate Public Education, Including Necessary Mental Health Care.*** In 1976, Congress guaranteed handicapped children the right to a free appropriate public education, including necessary related services for a child to benefit from his or her education.

☑ ***Legislature Shifted School and County Responsibilities for Mental Health Services.***

- Between 1976 and 1984, schools provided mental health services to special education pupils who needed the services to benefit from their Individualized Education Plans (IEP).
- In 1984, the Legislature assigned county mental health departments the responsibility for providing students these services (Chapter 1747, Statutes of 1984 [AB 3632, W. Brown]), except students placed out of state.
- In 1996, the Legislature expanded county responsibilities to include services to students placed in out-of-state schools. (Chapter 654, Statutes of 1995 [AB 2726, Woods]).

☑ ***Counties Provide a Range of Services.*** Approximately 20,000 special education pupils receive mental health services under the AB 3632 program. About half of the students are enrolled in the Medi-Cal Program. Common mental health disorders in this population include attention deficit hyperactivity and disruptive behavior disorders, as well as depression and bi-polar disorders. Services provided include mental health assessments, case management, individual and group therapy, rehabilitative counseling, day treatment, and medication support.

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AB 3632 Program Funding: Annual Costs Exceed $280 Million

(In Millions)	2007-08	2008-09	2009-10	2010-11 (May Revision)
Funding Provided to Counties				
Federal special education (redirected from schools)	$69	$69	$69	$69
Department of Mental Health categorical[a]	52	104	52	—
Department of Social Services Foster Care	48	51	59	70
Mandate reimbursements[b]	82	36	na	—
Funding Provided to Schools				
Proposition 98 support for schools	$31	$31	$31	$31
Total Resources	**$282**	**$291**	**$211**	**$170**

[a] Funding used to pay program costs across multiple years. The 2009-10 amount reflects Control Section 18.40.

[b] Claims for mandated activities in year shown. Additional claims for 2008-09 and 2009-10 activities forthcoming.

☑ ***Direct Support to Counties.*** Counties receive federal special education funds ($69 million) and General Fund resources from the Departments of Mental Health (DMH) and Social Services (DSS). Counties also receive funding from Medi-Cal (not shown in table).

☑ ***Mandate Reimbursements.*** The Commission on State Mandates determined that any residual county program costs are a state-reimbursable mandate. The Constitution requires the state to pay mandate bills or suspend or repeal the mandate. (Bills from before 2004 and all education mandates are exempt from this requirement.) Typically, the state pays mandate bills two years *after* the local government carries out the activity.

☑ ***Schools Receive Funding for Assessment and Pre-Intervention Services ($31 Million).***

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LAO Assessment of Current Program Model

- ☑ ***Weak State Mechanisms to Control Costs.*** Existing approach to delivery of AB 3632 services, by which the state reimburses counties for the provision of mental health services after-the-fact in response to claims, does not provide strong cost-control mechanisms or guarantee that state funds are well spent.

- ☑ ***Weak Linkages to Education.*** Current structure can result in inappropriate separation between county mental health and K-12 schools, whereby program services may lack sufficient input from educators or connection to students' educational outcomes.

- ☑ ***Lack of Accountability for Program Results.*** Existing program structure lacks element to measure how well counties achieve the program's goals.

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65 YEARS OF SERVICE

Administration May Revision Proposal

The administration proposes to "suspend" the county mandate to provide mental health services, thereby reverting responsibility for AB 3632 services to schools.

☑ ***State Law Allows the Legislature to Suspend Mandates in the Annual Budget.*** Under state law, suspending a mandate makes its provisions optional for one year. Suspending a mandate does not affect other provisions in the statute (those not determined to be a mandate).

☑ ***Constitution Appears to Allow Legislature to Defer Payments for Suspended Mandates.*** The state owes counties $133 million for AB 3632 mandated activities between 2004 and 2008. The administration proposes to defer paying counties for these costs.

☑ ***LAO Assessment of Governor's Proposal.*** We have a number of concerns with the Governor's approach.

- Suspending AB 3632 would be temporary, confusing, and disruptive.
- Proposal does not address the significant transitional issues associated with the change.
- Eliminating AB 3632 funding could violate federal special education spending maintenance-of-effort (MOE) requirements.

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LAO Alternative: Continue AB 3632 Mandate for One More Year

(In Millions)	Governor	Assembly	Senate	LAO
Funding Provided to Counties				
Federal special education	$69	$69	$69	$49[a]
Department of Mental Health categorical	—	52	52	—
Department of Social Services Foster Care	70	70	70	—
Mandate reimbursements	—	132	79	133
Funding Provided to Schools				
Proposition 98 support for schools	$31	$31	$31	$31
Federal special education	—	—	—	20[a]
Total Resources	**$170**	**$354**	**$301**	**$233**

[a] Some federal funds would be shifted back to schools willing to resume mental health responsibilities on a pilot basis in 2010-11.

☑ ***Satisfy Constitutional Obligation to Pay Outstanding Mandate Bills ($133 Million).*** Redirect all AB 3632 funds under DSS ($70 million) and DMH ($52 million) and provide additional General Fund ($11 million). Redirect $20 million in federal funds for some schools to pilot transition.

☑ ***Repeal the AB 3632 Mandate (Effective July 1, 2011) and Clarify Schools' Responsibility Under Federal Law.*** Reaffirm that federal Individuals with Disabilities Education Act requires schools to provide mental health services contained in a student's IEP. Clarify that state law does not require anything additional.

☑ ***Convene Work Group to Address Transitional Issues.*** Invite stakeholders to work on transition, including issues related to: funding for schools, county mental health's role, and continuity of care for students.

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Assessment of LAO Alternative

☑ **Strengths**

- ***Establishes Process and Timeline for Transition of Responsibilities and Services.*** Would help ensure continuity of care for students and enable agencies to prepare for change.
- ***Transparent and Permanent.*** Unlike suspension, no confusion over which entity is responsible for providing services or uncertainty over whether policy might change.
- ***Encourages More Cost-Effective Provision of Services.*** By eliminating automatic mandate reimbursement, creates incentives for schools to manage costs and use limited funds wisely. Does not preclude schools from contracting with county mental health agencies to continue providing services.
- ***Refocuses Emphasis on Students' Educational Needs.*** Consistent with federal law, reorients the program towards what students need to be successful in school.
- ***Strengthens Accountability.*** Existing school accountability system can be used to assess student outcomes and program effectiveness.

☑ **Limitations**

- ***Near Term County Fiscal Pressure.*** Requires counties to continue program for one year without fully funding program costs. Counties will be reimbursed for these costs over time.
- ***Defers Some State Costs for Program to Future.*** Future costs include any unreimbursed 2010-11 county program costs and funds required to satisfy federal special education MOE.

LEGISLATIVE AGENDA ITEM DETAIL SHEET

BILL NUMBER/ISSUE: Assembly Bill (AB) 181

BILL SUMMARY: This bill seeks to add mental health services as an enumerated (listed) right for children in foster care.

BACKGROUND: Currently, children who are removed from their family by a juvenile court are given enumerated (listed) rights by existing law; however, missing from those rights are mental health treatment rights.

ANALYSIS/DISCUSSION: When a child is removed from their family, a child can become confused and withdrawn and need mental health services. Although existing law provides rights that include care, placement, investigation and other services, no specific rights are provided with regard to mental health services.

This bill would make it a specific right for foster children to receive necessary mental health services, make a choice regarding therapy and the individual therapist, and to refuse mental health services unless deemed medically necessary by a court.

One major concern is that there is no specific right to refuse psychotropic medication unless the child experiences potentially dangerous side effects or experiences significant drug interactions. Although the bill provides children the right to refuse mental health treatment, it is of significant concern that the right to refuse psychotropic medication is not listed as a right.

COUNCIL STRATEGIC PLAN OBJECTIVE: Shape public policy that positively impacts Californians with developmental disabilities and their families.

PRIOR COUNCIL ACTIVITY: None

RECOMMENDATION(S): It is recommended that the Council support this bill if amended to reflect a right of refusal of psychotropic medications.

ATTACHMENT(S): AB 181

PREPARED: Melissa C. Corral, January 31, 2011

ASSEMBLY BILL No. 181

Introduced by Assembly Member Portantino
(Principal coauthor: Senator Steinberg)

January 24, 2011

An act to amend Section 16164 of, and to add Section 16001.10 to, the Welfare and Institutions Code, relating to foster youth.

LEGISLATIVE COUNSEL'S DIGEST

AB 181, as introduced, Portantino. Foster youth: mental health bill of rights.

Existing law provides that, when a child is removed from his or her family by the juvenile court, placement of the child in foster care should secure, as nearly as possible, the custody, care, and discipline equivalent to that which should have been given the child by his or her parents. Existing law provides enumerated rights for children who are placed in foster care. Existing law establishes the Office of the State Foster Care Ombudsperson to disseminate specified information, including the stated rights of foster youth, and to investigate and attempt to resolve complaints made by or on behalf of children placed in foster care, related to their care, placement, or services.

This bill would enumerate rights for foster youth relating to mental health services. The bill would require the office, in consultation with various entities, to develop, no later than July 1, 2012, standardized information explaining the rights specified and to distribute this information to foster youth.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 16001.10 is added to the Welfare and Institutions Code, to read:

16001.10. (a) It is the policy of the state that all children in foster care shall have the following rights relating to mental health services:

(1) To receive needed mental health services.

(2) To interview a therapist prior to commencing treatment.

(3) To discontinue psychotropic medication, as deemed appropriate by a physician, if the youth experiences potentially dangerous side effects.

(4) To be presented with mental health options, including, but not limited to, holistic or natural approaches, mentoring, peer counseling, therapy, and medication.

(5) To continue services with their therapist or counselor when their residential placement changes for at least one year, or as long as it is in the best interest of the youth, as determined by a court.

(6) To be evaluated by a medical professional.

(7) To have mental health services provided outside of the place of residence.

(8) To be provided with information on how to seek mental health services in their county of residence.

(9) To gain access to personal mental health records.

(10) Consistent with other state laws, to be guaranteed the protection of confidentiality when interacting with mental health professionals, unless the youth is deemed at risk of harming himself or herself or others.

(11) To be given age-appropriate information on drug interactions if prescribed more than one psychotropic medication.

(12) To receive timely mental health services in the county of residence and not to be denied services because of the county of origin.

(13) To refuse mental health treatment at any time unless deemed medically necessary by the court.

(b) The Office of the State Foster Care Ombudsperson, in consultation with the State Department of Mental Health, the Department of Public Health, the State Department of Health Care Services, foster youth advocacy and support groups, and groups representing children, families, foster parents, and children's

facilities, and other interested parties, shall develop, no later than July 1, 2012, standardized information explaining the rights specified in this section. The information shall be presented in an age-appropriate manner and shall reflect any relevant licensing requirements and medical information laws.

SEC. 2. Section 16164 of the Welfare and Institutions Code is amended to read:

16164. (a) The Office of the State Foster Care Ombudsperson shall do all of the following:

(1) Disseminate information on the rights of children and youth in foster care and the services provided by the office. The rights of children and youths in foster care are listed in ~~Section~~ *Sections* 16001.9 *and 16001.10*. The information shall include notification that conversations with the office may not be confidential.

(2) Investigate and attempt to resolve complaints made by or on behalf of children placed in foster care, related to their care, placement, or services.

(3) Decide, in its discretion, whether to investigate a complaint, or refer complaints to another agency for investigation.

(4) Upon rendering a decision to investigate a complaint from a complainant, notify the complainant of the intention to investigate. If the office declines to investigate a complaint or continue an investigation, the office shall notify the complainant of the reason for the action of the office.

(5) Update the complainant on the progress of the investigation and notify the complainant of the final outcome.

(6) Document the number, source, origin, location, and nature of complaints.

(7) (A) Compile and make available to the Legislature all data collected over the course of the year including, but not limited to, the number of contacts to the toll-free telephone number, the number of complaints made, including the type and source of those complaints, the number of investigations performed by the office, the trends and issues that arose in the course of investigating complaints, the number of referrals made, and the number of pending complaints.

(B) Present this compiled data, on an annual basis, at appropriate child welfare conferences, forums, and other events, as determined by the department, that may include presentations to, but are not limited to, representatives of the Legislature, the County Welfare

Directors Association, child welfare organizations, children's advocacy groups, consumer and service provider organizations, and other interested parties.

(C) It is the intent of the Legislature that representatives of the organizations described in subparagraph (B) consider this data in the development of any recommendations offered toward improving the child welfare system.

(D) The compiled data shall be posted so that it is available to the public on the existing *Internet* Web site of the State Foster Care Ombudsperson.

(8) Have access to any record of a state or local agency that is necessary to carry out his or her responsibilities~~, and~~. *Representatives of the office* may meet or communicate with any foster child in his or her placement or elsewhere.

(b) The office may establish, in consultation with a committee of interested individuals, regional or local foster care ombudsperson offices for the purposes of expediting investigations and resolving complaints, subject to appropriations in the annual Budget Act.

(c) (1) The office, in consultation with the California Welfare Directors Association, Chief Probation Officers of California, foster youth advocate and support groups, groups representing children, families, foster parents, children's facilities, and other interested parties, shall develop, no later than July 1, 2002, standardized information explaining the rights specified in Section 16001.9. The information shall be developed in an age-appropriate manner, and shall reflect any relevant licensing requirements with respect to foster care providers' responsibilities to adequately supervise children in care.

(2) The office, counties, foster care providers, and others may use the information developed in paragraph (1) in carrying out their responsibilities to inform foster children and youth of their rights pursuant to Section 1530.91 of the Health and Safety Code, Sections 27 and 16501.1, and this section.

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LEGISLATIVE AGENDA ITEM DETAIL SHEET

Bill NUMBER/ISSUE: Senate Bill (SB) 121 (Liu), special education: incarcerated minors

BILL SUMMARY: This bill declares that it is the intent of the Legislature to improve special education services for incarcerated minors.

BACKGROUND: Senator Liu is the sponsor of SB 121, which is a spot bill. A spot bill is a bill that acts as a placeholder to be amended into a more substantial bill after the deadline to introduce bills has passed.

On 1/31/11, the Senator's staff confirmed that this bill is a placeholder for SB 1059 (Liu), which was vetoed last session. SB 1059 (Liu) eliminated an ambiguity of the law regarding students with disabilities who are in special education, are detained in juvenile hall, and are "parentless". Special education due process cases regarding this matter have been heard by the Office of Administrative Hearings (OAH). The decisions that have been issued vary widely – some have assigned responsibility to school districts, others to COE, and still others to the California Department of Education (CDE). SB 1059 made it very clear which local educational agency (LEA) is responsible for providing a free appropriate public education (FAPE) to the student.

Because of ambiguities in the law and the need to go to due process to resolve which LEA is responsible for providing a FAPE, proponents of SB 1059 argued that this has resulted in students being detained in juvenile hall for extended periods of time. If indeed students are being detained in juvenile hall unnecessarily as a result of ambiguity in the law, SB 1059 would have provided clarity to resolve this concern. Additionally, the Assembly Committee on Education's staff analysis indicated that the ongoing due process hearings and litigation result in added costs to LEAs and potentially increased costs of incarceration time for students with disabilities. It is for these reasons that the Council supported SB 1059 (Liu). The governor vetoed SB 1059 because of pending litigation...which continues at the time of this writing.

ANALYSIS/DISCUSSION: None at this time.

COUNCIL STRATEGIC PLAN OBJECTIVE: Shape public policy that positively impacts Californians with developmental disabilities and their families.

PRIOR COUNCIL ACTIVITY: The Council supported SB 1059.

RECOMMENDATION(S): It is recommended that the LPPC continue to monitor this bill. If amended into a bill that is the same as SB 1059, then support the bill.

ATTACHMENT(S): SB 121 and SB 1059 and veto message (prior session)

PREPARED: Christofer Arroyo, January 31, 2011

SENATE BILL **No. 121**

Introduced by Senator Liu

January 24, 2011

An act to add Section 56049 to the Education Code, relating to special education.

LEGISLATIVE COUNSEL'S DIGEST

SB 121, as introduced, Liu. Special education: incarcerated minors.

Existing law requires every individual with exceptional needs who is eligible to receive special education instruction and related services, as specified, to receive that instruction and those services at no cost to his or her parents or, as appropriate, to him or her.

This bill would state the intent of the Legislature to improve special education services for incarcerated minors.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 56049 is added to the Education Code, to read:

56049. It is the intent of the Legislature to improve special education services for incarcerated minors.

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BILL NUMBER: SB 1059
VETOED DATE: 09/30/2010

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To the Members of the California State Senate:

I am returning Senate Bill 1059 without my signature.

I have always been committed to ensuring that every child receives a free and appropriate public education, including students with special needs through the implementation of an Individualized Education Plan. This bill attempts to provide additional clarification on which local educational agency is responsible for foster care pupils with special needs who have been detained in a juvenile hall. While I appreciate the intent to address this complex issue, in light of pending litigation regarding this issue, it is premature to enact these statutory changes.

For this reason, I am unable to sign this bill.

Sincerely,

Arnold Schwarzenegger

52

Senate Bill No. 1059

Passed the Senate August 19, 2010

_____

Secretary of the Senate

Passed the Assembly August 16, 2010

_____

Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of _____, 2010, at _____ o'clock ___M.

_____

Private Secretary of the Governor

CHAPTER _____

An act to amend Sections 48204, 48645.2, and 56028 of the Education Code, relating to local educational agencies.

LEGISLATIVE COUNSEL'S DIGEST

SB 1059, Liu. Local educational agencies: districts of residence.

(1) Existing law provides for residency requirements for school attendance, including the requirement that a pupil placed within the boundaries of that school district in a regularly licensed children's institution, a licensed foster home, or a family home pursuant to a placement under a designated statute, is deemed to comply with residency requirements for that district.

This bill would provide that a school district into which a pupil is placed in a regularly licensed children's institution, a licensed foster home, or a family home pursuant to a placement under a designated statute is the district of residence. The bill would further require that this school district of residence would be responsible for providing the pupil with a free appropriate public education, as defined. Because this provision would impose new requirements on school districts, it would constitute a state-mandated local program.

(2) Existing law requires a minor under the jurisdiction of the juvenile court as a consequence of delinquent conduct, in conformity with the interests of public safety and protection, to receive care, treatment, and guidance that is consistent with his or her best interest, that holds the minor accountable for his or her behavior, and that is appropriate for his or her circumstances.

Existing law provides for the establishment of public schools in juvenile halls, juvenile homes, day centers, juvenile ranches, juvenile camps, regional youth educational facilities, or Orange County youth correctional centers, as specified, to provide juvenile court school pupils with quality education and training. Existing law requires a county board of education to provide for the administration and operation of juvenile court schools in the county, either by the county superintendent of schools, as specified, or by contract with the respective governing boards of the

elementary, high school, or unified school district in which the juvenile court school is located.

This bill would require that the county board of education is responsible for providing pupils detained in juvenile halls who are individuals with exceptional needs with a free appropriate public education, as defined. However, if the expanded individualized education program team determines that placement is appropriate, the bill would require the provider of educational services to determine the school district responsible for paying and providing for education placement, pursuant to criteria specified by the bill. Because this provision would impose new requirements on local educational agencies, it would constitute a state-mandated local program.

(3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

The people of the State of California do enact as follows:

SECTION 1. Section 48204 of the Education Code, as amended by Section 1 of Chapter 33 of the Statutes of 2007, is amended to read:

48204. (a) Notwithstanding Section 48200, a pupil complies with the residency requirements for school attendance in a school district, if he or she is any of the following:

(1) (A) (i) A pupil placed within the boundaries of that school district in a regularly established licensed children's institution, or a licensed foster home, or a family home pursuant to a commitment or placement under Chapter 2 (commencing with Section 200) of Part 1 of Division 2 of the Welfare and Institutions Code.

(ii) Notwithstanding Sections 48200 and 56028, for any pupil placed pursuant to clause (i), the school district in which the pupil resides is the district of residence, and it is that school district that is responsible for providing the pupil with a free appropriate public

education within the meaning of Section 1412 of Title 20 of the United States Code and Sections 104.33 and 300.104 of Title 34 of the Code of Federal Regulations, as these provisions exist on January 1, 2010, pursuant to residential placement as specified in Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code and Section 60200 of Title 2 of the California Code of Regulations, as it exists on January 1, 2010.

(B) An agency placing a pupil in a home or institution described in subparagraph (A) shall provide evidence to the school that the placement or commitment is pursuant to law.

(2) A pupil for whom interdistrict attendance has been approved pursuant to Chapter 5 (commencing with Section 46600) of Part 26.

(3) A pupil whose residence is located within the boundaries of that school district and whose parent or legal guardian is relieved of responsibility, control, and authority through emancipation.

(4) A pupil who lives in the home of a caregiving adult that is located within the boundaries of that school district. Execution of an affidavit under penalty of perjury pursuant to Part 1.5 (commencing with Section 6550) of Division 11 of the Family Code by the caregiving adult is a sufficient basis for a determination that the pupil lives in the home of the caregiver, unless the school district determines from actual facts that the pupil is not living in the home of the caregiver.

(5) A pupil residing in a state hospital located within the boundaries of that school district.

(b) A school district may deem a pupil to have complied with the residency requirements for school attendance in the district if at least one parent or the legal guardian of the pupil is physically employed within the boundaries of that district.

(1) This subdivision does not require the school district within which at least one parent or the legal guardian of a pupil is employed to admit the pupil to its schools. A school district shall not, however, refuse to admit a pupil under this subdivision on the basis, except as expressly provided in this subdivision, of race, ethnicity, sex, parental income, scholastic achievement, or any other arbitrary consideration.

(2) The school district in which the residency of either the parents or the legal guardian of the pupil is established, or the school district to which the pupil is to be transferred under this

subdivision, may prohibit the transfer of the pupil under this subdivision if the governing board of the district determines that the transfer would negatively impact the court-ordered or voluntary desegregation plan of the district.

(3) The school district to which the pupil is to be transferred under this subdivision may prohibit the transfer of the pupil if the district determines that the additional cost of educating the pupil would exceed the amount of additional state aid received as a result of the transfer.

(4) The governing board of a school district that prohibits the transfer of a pupil pursuant to paragraph (1), (2), or (3) is encouraged to identify, and communicate in writing to the parents or the legal guardian of the pupil, the specific reasons for that determination and is encouraged to ensure that the determination, and the specific reasons therefor, are accurately recorded in the minutes of the board meeting in which the determination was made.

(5) The average daily attendance for pupils admitted pursuant to this subdivision is calculated pursuant to Section 46607.

(6) Unless approved by the sending school district, this subdivision does not authorize a net transfer of pupils out of a school district, calculated as the difference between the number of pupils exiting the district and the number of pupils entering the district, in a fiscal year in excess of the following amounts:

(A) For a school district with an average daily attendance for that fiscal year of less than 501, 5 percent of the average daily attendance of the district.

(B) For a school district with an average daily attendance for that fiscal year of 501 or more, but less than 2,501, 3 percent of the average daily attendance of the district or 25 pupils, whichever amount is greater.

(C) For a school district with an average daily attendance of 2,501 or more, 1 percent of the average daily attendance of the district or 75 pupils, whichever amount is greater.

(7) Once a pupil is deemed to have complied with the residency requirements for school attendance pursuant to this subdivision and is enrolled in a school in a school district the boundaries of which include the location where at least one parent or the legal guardian of a pupil is physically employed, the pupil does not have to reapply in the next school year to attend a school within that district and the district governing board shall allow the pupil to

attend school through grade 12 in that district if the parent or legal guardian so chooses and if at least one parent or the legal guardian of the pupil continues to be physically employed by an employer situated within the attendance boundaries of the district, subject to paragraphs (1) to (6), inclusive.

(c) This section shall become inoperative on July 1, 2012, and as of January 1, 2013, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2013, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 2. Section 48204 of the Education Code, as amended by Section 2 of Chapter 33 of the Statutes of 2007, is amended to read:

48204. Notwithstanding Section 48200, a pupil complies with the residency requirements for school attendance in a school district, if he or she is:

(a) (1) (A) A pupil placed within the boundaries of that school district in a regularly established licensed children's institution, or a licensed foster home, or a family home pursuant to a commitment or placement under Chapter 2 (commencing with Section 200) of Part 1 of Division 2 of the Welfare and Institutions Code.

(B) Notwithstanding Section 56028, for any pupil placed pursuant to subparagraph (A), the school district in which the pupil resides is the district of residence, and it is that school district that is responsible for providing the pupil with a free appropriate public education within the meaning of Section 1412 of Title 20 of the United States Code and Sections 104.33 and 300.104 of Title 34 of the Code of Federal Regulations, as these provisions exist on January 1, 2010, pursuant to residential placement as specified in Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code and Section 60200 of Title 2 of the California Code of Regulations, as it exists on January 1, 2010.

(2) An agency placing a pupil in the home or institution described in paragraph (1) shall provide evidence to the school that the placement or commitment is pursuant to law.

(b) A pupil for whom interdistrict attendance has been approved pursuant to Chapter 5 (commencing with Section 46600) of Part 26.

(c) A pupil whose residence is located within the boundaries of that school district and whose parent or legal guardian is relieved of responsibility, control, and authority through emancipation.

(d) A pupil who lives in the home of a caregiving adult that is located within the boundaries of that school district. Execution of an affidavit under penalty of perjury pursuant to Part 1.5 (commencing with Section 6550) of Division 11 of the Family Code by the caregiving adult is a sufficient basis for a determination that the pupil lives in the home of the caregiver, unless the school district determines from actual facts that the pupil is not living in the home of the caregiver.

(e) A pupil residing in a state hospital located within the boundaries of that school district.

(f) This section shall become operative on July 1, 2012.

SEC. 3. Section 48645.2 of the Education Code is amended to read:

48645.2. The county board of education shall provide for the administration and operation of juvenile court schools established pursuant to Section 48645.1:

(a) By the county superintendent of schools, provided that, in any county in which the board of supervisors is establishing or maintaining juvenile court schools on January 1, 1978, the county superintendent of schools may contract with the board of supervisors for the administration and operation of such schools if agreed upon between the board of education and the board of supervisors. In any event, the county superintendent of schools may contract with other educational agencies for supporting services to the same extent that school districts may contract with other such agencies.

(b) By contract with the respective governing boards of the elementary, high school, or unified school district in which the juvenile court school is located.

(c) This subdivision shall apply solely to pupils detained in juvenile halls pursuant to Article 23 (commencing with Section 850) of Chapter 2 of Part 1 of Division 2 of the Welfare and Institutions Code.

(1) For a pupil in a juvenile hall established pursuant to Section 48645.1, the county board of education is responsible for the provision of a free appropriate public education for individuals with exceptional needs. However, if the expanded individualized

education program (IEP) team determines, pursuant to Sections 7572.5 and 7573 of the Government Code and Sections 104.33 and 300.104 of Title 34 of the Code of Federal Regulations, as those sections exist on January 1, 2010, that residential placement is appropriate, all of the following apply with respect to which school district is responsible for paying and providing for the education placement:

(A) For a pupil who has a parent, as described in paragraph (1) or (4) of subdivision (a) of Section 56028, or who has a legal guardian, the school district where the parent or the legal guardian resides shall be the responsible school district.

(B) For a pupil who has a parent, as described in paragraph (2) or (5) of subdivision (a) of Section 56028, or for a pupil who has a responsible adult appointed in accordance with Section 361 of the Welfare and Institutions Code, the school district where the pupil will be placed for the residential placement shall be the responsible school district, unless the residential placement is out of state, in which case the school district where the child was last enrolled prior to placement in a juvenile hall shall be the responsible school district.

(2) The county office of education shall determine the responsible school district, as described in paragraph (1), and timely notify the responsible school district of its responsibility under this section.

(3) If a pupil is placed at a residential placement as described in this subdivision, the responsible school district, as determined pursuant to paragraph (2), shall remain the district of residence for that pupil throughout the duration of the residential placement, including, as necessary, after disposition of the pupil's juvenile delinquency case.

(4) If a determination is made by a properly constituted individualized education program team that a less restrictive environment is appropriate for the pupil, the responsible school district, as determined pursuant to paragraph (2), shall transition the pupil into a subsequent education placement, including by creating a transition plan as described in paragraph (4) of subdivision (b) of Section 56345. This subsequent education placement may be a public or nonpublic school certified by the State Department of Education.

(5) If a dispute arises regarding responsibility for education placement or services, the responsible school district, as determined by the county office of education where the juvenile hall is located pursuant to paragraph (2), shall implement the individualized education program, including, but not necessarily limited to, paying and providing for the education placement and any other related service, benefit, or aid within the meaning of Sections 7572.5 and 7573 of the Government Code and Sections 104.33 and 300.104 of Title 34 of the Code of Federal Regulations, as those sections exist on January 1, 2010, during the duration of the dispute. A school district impacted by the decision made pursuant to paragraph (2) may appeal to the county board of education where the juvenile hall is located, which shall issue a written decision within 60 days, and that decision shall be final.

(6) The responsible school district, as described in paragraph (2), shall immediately assume responsibility for the educational costs. If the responsible school district fails or refuses to assume the educational costs, the county superintendent of schools may draw a requisition against the funds of the responsible school district in favor of the provider of educational services.

SEC. 4. Section 56028 of the Education Code is amended to read:

56028. (a) "Parent" means any of the following:

(1) A biological or adoptive parent of a child.

(2) A foster parent if the authority of the biological or adoptive parents to make educational decisions on the child's behalf specifically has been limited by court order in accordance with Section 300.30(b)(1) or (2) of Title 34 of the Code of Federal Regulations.

(3) A guardian generally authorized to act as the child's parent, or authorized to make educational decisions for the child, including a responsible adult appointed for the child in accordance with Sections 361 and 726 of the Welfare and Institutions Code.

(4) An individual acting in the place of a biological or adoptive parent, including a grandparent, stepparent, or other relative, with whom the child lives, or an individual who is legally responsible for the child's welfare.

(5) A surrogate parent who has been appointed pursuant to Section 7579.5 or 7579.6 of the Government Code, and in accordance with Section 300.519 of Title 34 of the Code of Federal

Regulations and Section 1439(a)(5) of Title 20 of the United States Code.

(b) (1) Except as provided in paragraph (2), the biological or adoptive parent, when attempting to act as the parent under this part and when more than one party is qualified under subdivision (a) to act as a parent, shall be presumed to be the parent for purposes of this section unless the biological or adoptive parent does not have legal authority to make educational decisions for the child.

(2) If a judicial decree or order identifies a specific person or persons under paragraphs (1) to (4), inclusive, of subdivision (a) to act as the "parent" of a child or to make educational decisions on behalf of a child, then that person or persons shall be determined to be the "parent" for purposes of this part, Article 1 (commencing with Section 48200) of Chapter 2 of Part 27, and Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code, and Sections 361 and 726 of the Welfare and Institutions Code.

(c) "Parent" does not include the state or any political subdivision of government.

(d) "Parent" does not include a nonpublic, nonsectarian school or agency under contract with a local educational agency for the provision of special education or designated instruction and services for a child.

(e) For a pupil placed pursuant to subparagraph (A) of paragraph (1) of subdivision (a) of Section 48204, the school district of residence is the school district wherein the pupil resides. The residence of the person or persons listed in paragraph (5) of subdivision (a), or paragraph (2) of subdivision (b), of this section does not determine the school district of residence.

SEC. 5. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

LEGISLATIVE AGENDA ITEM DETAIL SHEET

BILL NUMBER/ISSUE: Assembly Bill (AB) 154 (introduced last session as AB 1600)

BILL SUMMARY: This bill seeks to expand health care coverage to include the diagnosis and treatment of a mental illness of a person of any age and would define mental illness for this purpose.

BACKGROUND: During the last legislative session, Assemblymember Beall introduced a similar bill which was not passed; however, the Legislative and Public Policy Committee reviewed the bill thoroughly and although supported, the former bill created a "two-tier system" that was criticized. AB 154 includes the same provisions.

ANALYSIS/DISCUSSION: Currently, most health plans operate by allowing the consumer to select a primary care physician who coordinates the consumer's medical care; however, consumers must contact the health plan directly to receive prior authorization to obtain mental health services. This is especially problematic for people with disabilities or people who are aging because it makes access to services more difficult.

AB 154 seeks to make the process much simpler; this bill would mandate that mental health services are treated the same way as physical health services. This process would make it much easier for individuals to receive the mental health care services they need and also coordinated by their primary care physician.

The issue that remains in the bill is the "two tier system." The bill specifically leaves out people who are covered by the Public Employees Retirement System (State workers among them.) In addition, Medicare supplement plans are also excluded which may be a concern. Although most individuals on Medicare purchase a Health Maintenance Organization (HMO) or gap plan, others purchase supplemental plans since they offer better coverage, but those individuals would not be covered by this bill.

COUNCIL STRATEGIC PLAN OBJECTIVE: Shape public policy that positively impacts Californians with developmental disabilities and their families. (H.E. 1.1)

PRIOR COUNCIL ACTIVITY: The Council sent a letter regarding AB 1600 which supported the bill and encouraged amendments.

RECOMMENDATION(S): It is recommended that the Council support AB 154 with amendments.

ATTACHMENT(S): AB 154, Council letter on AB 1600, and AB 1600 with veto message.

PREPARED: Melissa C. Corral, January 31, 2011

ASSEMBLY BILL No. 154

Introduced by Assembly Member Beall

January 18, 2011

An act to add Section 22856 to the Government Code, to add Section 1374.74 to the Health and Safety Code, and to add Section 10144.8 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 154, as introduced, Beall. Health care coverage: mental health services.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Under existing law, a health care service plan contract and a health insurance policy are required to provide coverage for the diagnosis and treatment of severe mental illnesses of a person of any age. Existing law does not define "severe mental illnesses" for this purpose but describes it as including several conditions.

This bill would expand this coverage requirement for certain health care service plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2012, to include the diagnosis and treatment of a mental illness of a person of any age and would define mental illness for this purpose as a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders IV, including substance abuse but excluding nicotine dependence and specified diagnoses defined in the manual, subject to regulatory revision,

as specified. The bill would specify that this requirement does not apply to a health care benefit plan, contract, or health insurance policy with the Board of Administration of the Public Employees' Retirement System unless the board elects to purchase a plan, contract, or policy that provides mental health coverage.

Because this bill would expand coverage requirements for health care service plans, the willful violation of which would be a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 22856 is added to the Government Code, to read:

22856. The board may purchase a health care benefit plan or contract or a health insurance policy that includes mental health coverage as described in Section 1374.74 of the Health and Safety Code or Section 10144.8 of the Insurance Code.

SEC. 2. Section 1374.74 is added to the Health and Safety Code, to read:

1374.74. (a) A health care service plan contract issued, amended, or renewed on or after January 1, 2012, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of a mental illness of a person of any age, including a child, under the same terms and conditions applied to other medical conditions as specified in subdivision (c) of Section 1374.72. The benefits provided under this section shall include all those set forth in subdivision (b) of Section 1374.72.

(b) (1) "Mental illness" for the purposes of this section means a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders IV, published by the American Psychiatric Association, and includes substance abuse, but excludes treatment of the following diagnoses, all as defined in the manual:

(A) Noncompliance With Treatment (V15.81).
(B) Partner Relational Problem (V61.1).
(C) Physical/Sexual Abuse of an Adult (V61.12).
(D) Parent-Child Relational Problem (V61.20).
(E) Child Neglect (V61.21).
(F) Physical/Sexual Abuse of a Child (V61.21).
(G) Sibling Relational Problem (V61.8).
(H) Relational Problem Related to a Mental Disorder or General Medical Condition (V61.9).
(I) Occupational Problem (V62.29).
(J) Academic Problem (V62.3).
(K) Acculturation Problem (V62.4).
(L) Relational Problems (V62.81).
(M) Bereavement (V62.82).
(N) Physical/Sexual Abuse of an Adult (V62.83).
(O) Borderline Intellectual Functioning (V62.89).
(P) Phase of Life Problem (V62.89).
(Q) Religious or Spiritual Problem (V62.89).
(R) Malingering (V65.2).
(S) Adult Antisocial Behavior (V71.01).
(T) Child or Adolescent Antisocial Behavior (V71.02).
(U) There is not a Diagnosis or a Condition on Axis I (V71.09).
(V) There is not a Diagnosis on Axis II (V71.09).
(W) Nicotine Dependence (305.10).

(2) Following publication of each subsequent volume of the manual, the definition of "mental illness" shall be subject to revision to conform to, in whole or in part, the list of mental disorders defined in the then-current volume of the manual.

(3) Any revision to the definition of "mental illness" pursuant to paragraph (2) shall be established by regulation promulgated jointly by the department and the Department of Insurance.

(c) (1) For the purpose of compliance with this section, a plan may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan and shall not be required to obtain an additional or specialized license for this purpose.

(2) A plan shall provide the mental health coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that

provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

(3) In the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing to the extent permitted by law or regulation.

(d) Nothing in this section shall be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a plan provides coverage for prescription drugs.

(e) This section shall not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.

(f) This section shall not apply to a health care benefit plan or contract entered into with the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code) unless the board elects, pursuant to Section 22856 of the Government Code, to purchase a health care benefit plan or contract that provides mental health coverage as described in this section.

(g) This section shall not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only health care service plan contracts.

SEC. 3. Section 10144.8 is added to the Insurance Code, to read:

10144.8. (a) A policy of health insurance that covers hospital, medical, or surgical expenses in this state that is issued, amended, or renewed on or after January 1, 2012, shall provide coverage for the diagnosis and medically necessary treatment of a mental illness of a person of any age, including a child, under the same terms and conditions applied to other medical conditions as specified in subdivision (c) of Section 10144.5. The benefits provided under

this section shall include all those set forth in subdivision (b) of Section 10144.5.

(b) (1) "Mental illness" for the purposes of this section means a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders IV, published by the American Psychiatric Association, and includes substance abuse, but excludes treatment of the following diagnoses, all as defined in the manual:

(A) Noncompliance With Treatment (V15.81).
(B) Partner Relational Problem (V61.1).
(C) Physical/Sexual Abuse of an Adult (V61.12).
(D) Parent-Child Relational Problem (V61.20).
(E) Child Neglect (V61.21).
(F) Physical/Sexual Abuse of a Child (V61.21).
(G) Sibling Relational Problem (V61.8).
(H) Relational Problem Related to a Mental Disorder or General Medical Condition (V61.9).
(I) Occupational Problem (V62.29).
(J) Academic Problem (V62.3).
(K) Acculturation Problem (V62.4).
(L) Relational Problems (V62.81).
(M) Bereavement (V62.82).
(N) Physical/Sexual Abuse of an Adult (V62.83).
(O) Borderline Intellectual Functioning (V62.89).
(P) Phase of Life Problem (V62.89).
(Q) Religious or Spiritual Problem (V62.89).
(R) Malingering (V65.2).
(S) Adult Antisocial Behavior (V71.01).
(T) Child or Adolescent Antisocial Behavior (V71.02).
(U) There is not a Diagnosis or a Condition on Axis I (V71.09).
(V) There is not a Diagnosis on Axis II (V71.09).
(W) Nicotine Dependence (305.10).

(2) Following publication of each subsequent volume of the manual, the definition of "mental illness" shall be subject to revision to conform to, in whole or in part, the list of mental disorders defined in the then-current volume of the manual.

(3) Any revision to the definition of "mental illness" pursuant to paragraph (2) shall be established by regulation promulgated jointly by the department and the Department of Managed Health Care.

(c) (1) For the purpose of compliance with this section, a health insurer may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan and shall not be required to obtain an additional or specialized license for this purpose.

(2) A health insurer shall provide the mental health coverage required by this section in its entire in-state service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health insurers are not precluded from requiring insureds who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

(3) In the provision of benefits required by this section, a health insurer may utilize case management, managed care, or utilization review to the extent permitted by law or regulation.

(4) Any action that a health insurer takes to implement this section, including, but not limited to, contracting with preferred provider organizations, shall not be deemed to be an action that would otherwise require licensure as a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(d) This section shall not apply to accident-only, specified disease, hospital indemnity, or Medicare supplement insurance policies, or specialized health insurance policies, except behavioral health-only policies.

(e) This section shall not apply to a policy of health insurance purchased by the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code) unless the board elects, pursuant to Section 22856 of the Government Code, to purchase a policy of health insurance that covers mental health services as described in this section.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school

district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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CALIFORNIA SCDD
State Council on Developmental Disabilities

STATE OF CALIFORNIA
Arnold Schwarzenegger,
Governor

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August 24, 2010

The Honorable Jim Beall Jr.
California State Assembly
Capitol Building, Room 5016
Sacramento, CA 95814

RE: AB 1600 (Beall)
Position: Support with amendments encouraged

Dear Assembly Member Beall,

The State Council on Developmental Disabilities is a State agency whose mission is to advocate, promote and implement policies and practices that achieve self-determination, independence, productivity and inclusion in all aspects of community life for Californians with developmental disabilities and their families. Additionally, the Council has 13 local Area Boards, covering all regions of the state. It is on behalf of over 200,000 Californians with a developmental disability that I write today to convey our support with amendments encouraged for AB 1600 (Beall).

AB 1600 (Beall) expands health care coverage by appropriately defining "mental illness". In doing so, people with mental illness will be eligible to receive the same standard of care as those with physical health care issues. Additionally, this legislation will prevent insurance carriers from attempting to narrow their coverage. However, AB 1600 (Beall) specifically gives the California Public Employees' Retirement System the option to provide the mental health coverage or not. In effect, this permissive language would create a two-tier system for Californians, one for California's 245,000 state employees and another for other Californians. We therefore encourage you to introduce an amendment that would avoid such a two-tier system.

Because we anticipate that this bill is likely to lead to more people with disabilities to have health care coverage for their mental health needs, we support AB 1600 (Beall).

We thank you for your consideration of our input. If you have any questions, please do not hesitate to contact us.

Sincerely,

Marcia Good
Chair

cc: Honorable Members of the Assembly Appropriations Committee
Mr. Geoff Long, Chief Consultant, Assembly Appropriations Committee
Honorable Members of the Assembly Health Committee
Ms. Teri Boughton, Chief Consultant, Assembly Health Committee
Honorable Members of the Senate Appropriations Committee
Mr. Bob Franzoia, Staff Director, Senate Appropriations Committee
Honorable Members of the Senate Health Committee
Mr. Peter Hansel, Staff Director, Senate Health Committee

BILL NUMBER: AB 1600
VETOED DATE: 09/29/2010

To the Members of the California State Assembly:
I am returning Assembly Bill 1600 without my signature.
This is the fourth time that I have vetoed this measure. In addition to the concerns that I have consistently cited over the last three vetoes regarding the overall rising cost of healthcare and lack of affordability for employers and individuals struggling to keep their existing coverage, I am now able to add a new concern. The federal health reform provisions that take effect in 2014 will require states to pay the entire cost of mandates that go above and beyond the definition of "essential benefits." This bill certainly requires a higher level of service than contemplated on a federal level and as such, will mandate California to spend new General Fund dollars for these benefits.
I cannot agree to a significant expenditure of new funds when we are struggling to provide basic levels of coverage to our most needy and fragile populations.
Sincerely,

Arnold Schwarzenegger

Assembly Bill No. 1600

Passed the Assembly August 26, 2010

_____

Chief Clerk of the Assembly

Passed the Senate August 25, 2010

_____

Secretary of the Senate

This bill was received by the Governor this _____ day of _____, 2010, at _____ o'clock ___M.

_____

Private Secretary of the Governor

CHAPTER _____

An act to add Section 22856 to the Government Code, to add Section 1374.74 to the Health and Safety Code, and to add Section 10144.8 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1600, Beall. Health care coverage: mental health services.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Under existing law, a health care service plan contract and a health insurance policy are required to provide coverage for the diagnosis and treatment of severe mental illnesses of a person of any age. Existing law does not define "severe mental illnesses" for this purpose but describes it as including several conditions.

This bill would expand this coverage requirement for certain health care service plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2011, to include the diagnosis and treatment of a mental illness of a person of any age and would define mental illness for this purpose as a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders IV, including substance abuse but excluding nicotine dependence and specified diagnoses defined in the manual, subject to regulatory revision, as specified. The bill would specify that this requirement does not apply to a health care benefit plan, contract, or health insurance policy with the Board of Administration of the Public Employees' Retirement System unless the board elects to purchase a plan, contract, or policy that provides mental health coverage.

Because this bill would expand coverage requirements for health care service plans, the willful violation of which would be a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the

state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 22856 is added to the Government Code, to read:

22856. The board may purchase a health care benefit plan or contract or a health insurance policy that includes mental health coverage as described in Section 1374.74 of the Health and Safety Code or Section 10144.8 of the Insurance Code.

SEC. 2. Section 1374.74 is added to the Health and Safety Code, to read:

1374.74. (a) A health care service plan contract issued, amended, or renewed on or after January 1, 2011, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of a mental illness of a person of any age, including a child, under the same terms and conditions applied to other medical conditions as specified in subdivision (c) of Section 1374.72. The benefits provided under this section shall include all those set forth in subdivision (b) of Section 1374.72.

(b) (1) "Mental illness" for the purposes of this section means a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders IV, published by the American Psychiatric Association, and includes substance abuse, but excludes treatment of the following diagnoses, all as defined in the manual:

(A) Noncompliance With Treatment (V15.81).

(B) Partner Relational Problem (V61.1).

(C) Physical/Sexual Abuse of an Adult (V61.12).

(D) Parent-Child Relational Problem (V61.20).

(E) Child Neglect (V61.21).

(F) Physical/Sexual Abuse of a Child (V61.21).

(G) Sibling Relational Problem (V61.8).

(H) Relational Problem Related to a Mental Disorder or General Medical Condition (V61.9).

(I) Occupational Problem (V62.29).

(J) Academic Problem (V62.3).

(K) Acculturation Problem (V62.4).
(L) Relational Problems (V62.81).
(M) Bereavement (V62.82).
(N) Physical/Sexual Abuse of an Adult (V62.83).
(O) Borderline Intellectual Functioning (V62.89).
(P) Phase of Life Problem (V62.89).
(Q) Religious or Spiritual Problem (V62.89).
(R) Malingering (V65.2).
(S) Adult Antisocial Behavior (V71.01).
(T) Child or Adolescent Antisocial Behavior (V71.02).
(U) There is not a Diagnosis or a Condition on Axis I (V71.09).
(V) There is not a Diagnosis on Axis II (V71.09).
(W) Nicotine Dependence (305.10).

(2) Following publication of each subsequent volume of the manual, the definition of "mental illness" shall be subject to revision to conform to, in whole or in part, the list of mental disorders defined in the then-current volume of the manual.

(3) Any revision to the definition of "mental illness" pursuant to paragraph (2) shall be established by regulation promulgated jointly by the department and the Department of Insurance.

(c) (1) For the purpose of compliance with this section, a plan may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan and shall not be required to obtain an additional or specialized license for this purpose.

(2) A plan shall provide the mental health coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

(3) In the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing to the extent permitted by law or regulation.

(d) Nothing in this section shall be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a plan provides coverage for prescription drugs.

(e) This section shall not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.

(f) This section shall not apply to a health care benefit plan or contract entered into with the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code) unless the board elects, pursuant to Section 22856 of the Government Code, to purchase a health care benefit plan or contract that provides mental health coverage as described in this section.

(g) This section shall not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only health care service plan contracts.

SEC. 3. Section 10144.8 is added to the Insurance Code, to read:

10144.8. (a) A policy of health insurance that covers hospital, medical, or surgical expenses in this state that is issued, amended, or renewed on or after January 1, 2011, shall provide coverage for the diagnosis and medically necessary treatment of a mental illness of a person of any age, including a child, under the same terms and conditions applied to other medical conditions as specified in subdivision (c) of Section 10144.5. The benefits provided under this section shall include all those set forth in subdivision (b) of Section 10144.5.

(b) (1) "Mental illness" for the purposes of this section means a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders IV, published by the American Psychiatric Association, and includes substance abuse, but excludes treatment of the following diagnoses, all as defined in the manual:

(A) Noncompliance With Treatment (V15.81).

(B) Partner Relational Problem (V61.1).

(C) Physical/Sexual Abuse of an Adult (V61.12).

(D) Parent-Child Relational Problem (V61.20).
(E) Child Neglect (V61.21).
(F) Physical/Sexual Abuse of a Child (V61.21).
(G) Sibling Relational Problem (V61.8).
(H) Relational Problem Related to a Mental Disorder or General Medical Condition (V61.9).
(I) Occupational Problem (V62.29).
(J) Academic Problem (V62.3).
(K) Acculturation Problem (V62.4).
(L) Relational Problems (V62.81).
(M) Bereavement (V62.82).
(N) Physical/Sexual Abuse of an Adult (V62.83).
(O) Borderline Intellectual Functioning (V62.89).
(P) Phase of Life Problem (V62.89).
(Q) Religious or Spiritual Problem (V62.89).
(R) Malingering (V65.2).
(S) Adult Antisocial Behavior (V71.01).
(T) Child or Adolescent Antisocial Behavior (V71.02).
(U) There is not a Diagnosis or a Condition on Axis I (V71.09).
(V) There is not a Diagnosis on Axis II (V71.09).
(W) Nicotine Dependence (305.10).

(2) Following publication of each subsequent volume of the manual, the definition of "mental illness" shall be subject to revision to conform to, in whole or in part, the list of mental disorders defined in the then-current volume of the manual.

(3) Any revision to the definition of "mental illness" pursuant to paragraph (2) shall be established by regulation promulgated jointly by the department and the Department of Managed Health Care.

(c) (1) For the purpose of compliance with this section, a health insurer may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan and shall not be required to obtain an additional or specialized license for this purpose.

(2) A health insurer shall provide the mental health coverage required by this section in its entire in-state service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health insurers are not precluded from requiring insureds who reside or work in

geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

(3) In the provision of benefits required by this section, a health insurer may utilize case management, managed care, or utilization review to the extent permitted by law or regulation.

(4) Any action that a health insurer takes to implement this section, including, but not limited to, contracting with preferred provider organizations, shall not be deemed to be an action that would otherwise require licensure as a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(d) This section shall not apply to accident-only, specified disease, hospital indemnity, or Medicare supplement insurance policies, or specialized health insurance policies, except behavioral health-only policies.

(e) This section shall not apply to a policy of health insurance purchased by the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code) unless the board elects, pursuant to Section 22856 of the Government Code, to purchase a policy of health insurance that covers mental health services as described in this section.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Approved _____, 2010

_____

Governor

LEGISLATIVE AGENDA ITEM DETAIL SHEET

Bill NUMBER/ISSUE: 2011-12 Budget Trailer Bill Language

BILL SUMMARY: Proposed legislative changes to California statutes addressing: (1) Medi-Cal benefits; (2) SSI/SSP reduction; (3) Adult Day Health Care reductions; (4) regional center administrative costs; (5) regional center audits; (6) Medi-Cal pharmacy limitations; (7) regional center conflicts of interests; (8) Medi-Cal physician visits limitations; and (9) Medi-cal payment reductions.

BACKGROUND: There are generally budget changes proposed by the Governor or the Legislature which necessitate changes to existing law in order to implement the budget changes. If this is the case, separate bills are introduced to implement the change. These budget implementation bills are called "trailer bills" and are heard concurrently with the Budget Bill. By law, all proposed statutory changes necessary to implement the Governor's Budget are due to the Legislature by February 1.

ANALYSIS/DISCUSSION: The 2011-12 Governor's budget proposes several major fiscal reductions and changes that necessitate changes to existing law in order to be implemented, thus a series of trailer bills have been introduced to make these statutory changes.

Specifically the current proposals are as follows:

- Add Section 14131.05 to the Welfare and Institutions Code (WIC) to place a specific dollar cap on Medi-Cal spending per year for hearing aids, durable medical equipment, incontinence medical supplies, urological medical supplies, and wound care supplies. The bill also outlines what services are not affected by the proposed caps. (RN 02261)

- Add Section 12200.03 to WIC to reduce SSI/SSP payments to the minimum amount required by the federal Social Security Act. (RN 01850)

- Add Article 6, Chapter 8.7 of Part 3, Division 9 of WIC to eliminate adult day health care services to the extent allowed under federal law. (RN 02269)

- Add Section 4629.5 to WIC to require 85% of regional center funds be spent on direct services and defines "administrative services". (RN 03216)

- Amend Section 4639 and add Section 4652.5 WIC to prohibit regional centers from using the same accounting firm for more than 5 years in every 10 years; and requires any entity receiving regional center funds, with some exceptions, to contract with an independent auditing firm for an audit or review of its financial statements. (RN 007837)

- Amend Section 14133.32 WIC to place a limit on prescription drugs covered by Medi-Cal to 6 per month and defines some exceptions to this requirement. (RN 02249)

- Amend Sections 4626 and 4627 WIC addressing the conflict of interests related to regional center board members and employees. (RN 07802)

- Add Section 14131.07 WIC to limit the number of physician visits paid for by Medi-Cal to 10 per fiscal year with some exceptions. (RN 02263)

- Amend Section 14105.191 and add Section 14105.192 WIC to reduce Medi-Cal provider payments by 10% effective June 1, 2011. (RN 02245)

- Amend Section 12301 WIC to eliminate domestic services for In-Home Supportive Services (IHSS) recipients who live with a housemate unless the housemate is physically or mentally impaired thus prevented from performing these tasks. (RN 07552)

- Amend Section 12300 WIC to eliminate domestic services for IHSS recipients who are children living with their parent(s) unless the parent(s) is physically or mentally unable to perform the tasks. (RN 05078)

- Amend Section 12301.03, 12301.05 and 12301.06 WIC to reduce the amount of IHSS hours to a recipient by 3.6 percent **permanently** and further reduce them in 2011-12 by an additional 8.4 percent for a combined total of a 12% reduction. (RN 05159)

- Amend Section 12301 WIC to require IHSS applicants or recipients to obtain a certificate from a licensed physician or other appropriate medical professional indicating that due to functional limitations, the person is unable to perform the IHHS independently **and** without IHSS is a risk of placement in out-of-home placement. (RN 07849)

- Enact legislation to make the establishment of IHSS Advisory committee optional for counties. (RN number not available)

- Add Section 4648.8 WIC to require the Department of Developmental Services (DDS) to develop purchase of services standards for use by regional centers when purchasing services for consumers and families. (RN 07836)

- Add Article 2.6, commencing with Section 4659.10, to Chapter 5 of Division 4.5 WIC to establish procedures authorizing DDS or regional centers to institute legal proceedings against a third party or insurance carrier when services are provided or will be provided to a consumer or a child under 36 months of age who is eligible for the California Early Intervention Program (Early Start) as a result of an injury for which the third part is liable; recover the reasonable value of services provided from the person who has brought an action or claim against a third party who may in this situation; and establish procedures for the enforcement of a lien perfected by DDS or a regional center upon a judgment or award in favor of a child or consumer for a third party injury and other related provisions. (RN 07840)

- Amend Section 4474.5 WIC to clarify that consumers transitioning from Agnews Developmental Center (ADC) be served by the county organized Medi-Cal managed health care system or a local initiative, if consumers choose to enroll; and require consumers transitioning from Lanterman Developmental Center (LDC) to receive Medi-Cal managed care health plan services from any plan operating in various counties if the consumer chooses to enroll; that managed care plans enrolling LDC consumers will be reimbursed by a supplemental capitation payment for specified services, but not for LDC staff, and defines reasonable cost and reasonable net cost. (RN 07838)

- Add Sections 4622.5, 4629.5, 4648.12 and 4648.14 WIC to require regional centers to annually submit to DDS documentation demonstrating that the composition of their boards are in compliance with the law; require regional center boards to adopt a written policy requiring any contract over $350,000 to be approved by the board; require the policy be posted on the center's web site; require DDS establish a transparency portal on its web site and link to the regional centers' sites; and require that persons or entities that have been convicted of prescribed crimes or have been found liable for fraud or abuse in any civil proceeding or have entered into as settlement in lieu of conviction of fraud or abuse in any government program within the previous 10 years be ineligible to be a regional center vendor. (RN 07801)

- Amend Section 14132 WIC to, in the Medi-Cal program, require enteral nutrition products for persons 21 years or older be limited to those products administered through gastric, nasogastric or jejunostomy tube. (RN 02272)

- Amend Section 14133.22 WIC to remove the prior authorization requirement and, instead, provide an exception from the limit on prescription drugs for patients

receiving care in a nursing facility, pregnancy-related services, children under 21, and specifically exempted drugs. (RN 07749)

- Amend Sections 14167.1, 14167.4, 14167.6, 14167.9, 14167.11, 14167.13, 14167.14, 14167.17, 14167.31, 14167.32, 14167.354, 14167.36, 14167.40 and 14167.41 and add Sections 14167.171 and 14167.391 to revise copayment rates and expand the services for which co-payments are due for Medi-Cal services. (RN 02250)

- Amend Sections 9562, 9565, 9567; renumber Section 1432.99 and repeal Section 9568 of WIC to allow the Director of the Department of Health Care Services (DHCS) to declare the increase in the state's federal medical assistant percentage (FMAP) pursuant to the federal American Recovery and Reinvestment Act of 2009 (ARRA) is no longer available, thus each individual will pay a monthly premium that is equal to 5% of his or her individual or spousal countable income as a Medi-Cal premium, except as provided in law, provided that such declaration does not jeopardize the state's ability to receive certain federal funds. (RN 004410)

- Amend Section 14132 WIC to provide that over-the-counter cough and cold products would **not** be covered by Medi-Cal. (RN 02247)

- Amend and repeal Section 14134.1 and amend, repeal and add Section 14134 WIC to revise the copayment rates, expand services requiring co-payments and reduce the amount of payment to providers by the amount of co-payments from the recipients in the Medi-Cal program. (RN 02248)

COUNCIL STRATEGIC PLAN OBJECTIVE: Shape public policy that positively impacts Californians with developmental disabilities and their families.

PRIOR COUNCIL/COMMITTEE ACTIVITY: LPPC adopted the attached positions on fiscal proposal in the Governor's 2011-12 Budget which corresponds to these proposed statutory changes. The Council Executive Committee will be considering the LPPC action on February 8, 2011.

RECOMMENDATION(S): Based upon the LPPC actions relative to the budget proposals, staff recommends the following actions related to the associated statutory proposals:

- **Oppose** language to establish a specific dollar cap on Medical spending per year for hearing aids, durable medical equipment, incontinence medical supplies, urological medical supplies, and wound care supplies. (RN 02261)

- **Oppose** language to reduce SSI/SSP payments to the minimum amount required by the federal Social Security Act. (RN 01850)

- **Oppose** language to eliminate adult day health care services to the extent allowed under federal law. (RN 02269)

- **Support** language to require 85% of regional center funds be spent on direct services and defines "administrative services". May wish to request amendments that more clearly define which staff, using the core staffing formula, provides direct services as opposed to administrative services to assure statewide continuity of implementation. (RN 03216)

- **Support** language to prohibit regional centers from using the same accounting firm for more than 5 years in every 10 years; and requires any entity receiving regional center funds, with some exceptions, to contract with an independent auditing firm for an audit ore review of its financial statements. (RN 007837)

- **Oppose** language to place a limit on prescription drugs covered by Medi-Cal to 6 per month. (RN 02249)

- **Support** language addressing the conflict of interests related to regional center board members and employees. (RN 07802)

- **Oppose** language to limit the number of physician visits paid for by Medi-Cal to 10 per fiscal year. (RN 02263)

- To the extent that 10% reductions to Medi-Cal provider payments negatively impacts access to services, **oppose** the proposed statutory change. (RN 02245)

- **Oppose** language to eliminate domestic services for In-Home supportive Services (IHSS) recipients who live with a housemate. (RN 07552)

- **Oppose** language to eliminate domestic services for IHSS recipients who are children living with their parent(s). (RN 05078)

- **Oppose** language to reduce the amount of IHSS hours to a recipient by 3.6 percent **permanently** and further reduce them in 2011-12 by an additional 8.4 percent for a combined total of a 12% reduction. **Request language be amended to retain the current 3.5% reduction for 2011-12.** (RN 05159)

- **Oppose** language to require IHSS applicants or recipients to obtain a certificate from a licensed physician or other appropriate medical professional indicating that due to functional limitations, the person is unable to perform the IHHS independently **and** without IHSS is a risk of placement in out-of-home placement. (RN 07849)

- **No position** on language to make the establishment of IHSS Advisory Committees optional for counties. (No RN #)

- **Oppose** language to require the Department of Developmental Services (DDS) to develop purchase of services standards. **Once this open-ended statutory change is made, categorical reductions and elimination of services could be implemented, standards could be added or changed by the department in the future, and the values of the system would be reduced to protecting health and safety and the ability to access Medicaid waiver funds, as oppose to enhancing the independence, productivity, inclusion and self-determination of those served in the system.** (RN 07836)

- **Support** language to establish procedures authorizing DDS or regional centers to institute legal proceedings against a third party or insurance carrier when services are provided or will be provided to a consumer or a child under 36 months of age who is eligible for the California Early Intervention Program (Early Start) as a result of an injury for which the third part is liable and other related provisions. (RN 07840)

- **Withhold position and seek clarification** on language that consumers transitioning from Agnews Developmental Center (ADC) be served by the county organized Medi-Cal managed health care system or a local initiative, if consumers choose to enroll; and require consumers transitioning from Lanterman Developmental Center (LDC) to receive Medi-Cal managed care health plan services from any plan operating in various counties if the consumer chooses to enroll; that managed care plans enrolling LDC consumers will be reimbursed by a supplemental capitation payment for specified services, but not for LDC staff, and defines reasonable cost and reasonable net cost. **How does this proposal coordinate with implementation of the new Medicaid managed Care waiver that requires Medi-Cal recipients to be enrolled in managed care in most instances? Why this language is needed except to obtain the proposed supplement capitation rates and why are these rates needed for this portion of the population?** (RN 07838)

- **Support** language to require regional centers to annually submit to DDS documentation demonstrating that the composition of their boards are in compliance with the law; require regional center boards to adopt a written policy

requiring any contract over $350,000 to be approved by the board and related provisions. (RN 07801)

- **Oppose** language to, in the Medi-Cal program, requiring enteral nutrition products for persons 21 years or older be limited to those products administered through gastric, nasogastric or jejunostomy tube. (RN 02272)

- **Oppose** language to provide an exception from the limit on prescription drugs for patients receiving care in a nursing facility, pregnancy-related services, children under 21, and specifically exempted drugs. **This creates a two tiered Medi-Cal program and promoted institutionalization in order to access necessary medications**. (RN 07749)

- **Oppose** language to allow the Director of the Department of Health Care Services (DHCS) to declare the increase in the state's federal medical assistant percentage (FMAP) pursuant to the federal American Recovery and Reinvestment Act of 2009 (ARRA) is no longer available, **thus each individual will pay a monthly premium that is equal to 5% of his or her individual or spousal countable income as a Medi-Cal premium**, except as provided in law, provided that such declaration does not jeopardize the state's ability to receive certain federal funds. **This shifts additional disproportionate burden onto the same people who will experience less income (SSI/SSP reductions), less support (IHSS reductions), fewer support services (regional center purchase of service standards and Medi-Cal service limitations), and added costs (Medi-Cal co-payments).** (RN 02250)

- **Oppose** language to provide that over-the-counter cough and cold products would not be covered by Medi-Cal. **(Note: many advocates believe this, as opposed to some or all of the other proposals is likely to pass as the perceived impact is low and not life threatening, however this could lead to increased emergency room visits and hospitalizations due to the lack of less intrusive treatment options).** (RN 02247)

- **Oppose** language to revise copayment rates and expand the services for which co-payments are due for Medi-Cal services. (RN 02248)

ATTACHMENT(S): Draft language for each provision discussed above and LPPC recommendations on specific budget proposals.

PREPARED: Carol J. Risley, February 2, 2011

Legislative and Public Policy Committee (LPPC)
2011-12 Governor's Budget

Actions and Recommendations for Executive Committee Action

Basic Principles

LPPC recommends that prior to adopting positions on individual budget proposals that the Executive Committee act on a set of basic principles as follows:

- *The Council recognizes the magnitude of California's fiscal crisis and that all Californians will be impacted by balancing the budget, thus individuals with developmental disabilities must share in this correction, but should not be expected to assume an inequitable portion of the burden.*

- *While budget proposals may define and refine the level of entitlement to services and supports in the developmental services system, they must not eliminate the entitlement to access, and to be served by the system for eligible individuals and families.*

- *Budget proposals must not result in people with developmental disabilities having their health and safety negatively impacted, jeopardize their inclusion in the community, force them to become less productive, and/or reduce their ability to direct their own lives and make choices.*

- *Budget proposals must not violate the basic tenet of the developmental services system as a civil/social rights model rather than medical model, nor reduce the quality of available services.*

- *Budget proposals must examine the entire system to seek administrative efficiencies and economies of scale, not just impact direct services.*

- *Budget proposals must not violate the basic underpinnings of existing federal and state statutes and court decisions that serve to assure the*

provision of quality services and supports and protect basic human rights of individuals with developmental disabilities.

Department of Developmental Services (DDS)

- *Any budget reductions must be shared by the entire developmental services system, not solely applied to community services, and more specifically purchase of services and supports for individuals with developmental disabilities.*

Community Services Program

- Proposed $149.7 million increase in Purchase of Services (POS) and Prevention Program due to increased caseload and utilization.
  - *Support*
- $0.5 million decrease due to the delayed implementation of the Self-Directed Services.
  - *Support, although the Council is extremely frustrated with the continued delay with implementing this option in California.*
- $13.0 million increase in regional center operations costs primarily due to caseload increases and additional Home and Community-Based Services (HCBS) waiver enrollments.
  - *Support*
- Increase of $134.1 million in General Fund and corresponding decrease in reimbursements due to the end of federal stimulus funding.
  - *Support*

- Continuation of the 4.25 percent payment reduction in 2011-12. The reduction impacts both regional center operations and POS for a total decrease of $165.5 million ($91.5 million General Fund). There is an incremental decrease from 2010-11 of $2.8 million due to the reduced total funding level in 2011-12.

  ▶ *Request proposal be reduced to 3% to mitigate the overall impact reduction has had on the availability and quality of services particularly when taking into consideration the cumulative effect of historic rate freezes and other reductions in services and supports over the past five years. See attached chart illustrating this cumulative effect.*

- Continue reimbursement funding from the California Children and Families Commission (Proposition 10) in 2011-12, resulting in a General Fund savings of $50 million.

  ▶ *Support*

- $27.2 million decrease in 2011-12, as the 2010-11 budget included costs associated with retroactive processing of claims for 2007-08 through 2010-11 (four years) that is not required in the budget year. These costs related to increasing Federal Financial Participation (FFP) for day treatment and transportation costs for residents of Intermediate Care Facilities for individuals with developmental disabilities (ICF-DD). The 2011-12 budget retains $9.5 million for budget year claims.

  ▶ *Support*

- $1.7 million increase to establish Financial Management Services (FMS) as an option for vouchered respite, transportation, and day care services consistent with federal requirements to renew the HCBS waiver.

  ▶ *Request additional explanation as to whom or what will provide these services, how $1.7 million be used and what are consumer/family protections related to this service.*

- $70.1 million increase to reflect the impact of service reductions proposals in Medi-Cal and SSI/SSP programs that will increase regional centers POS costs in 2011-12.

  ▶ *Support and request similar provision for individuals with developmental disabilities who will experience a decrease in needed In-Home Supportive Services (IHSS).*

- Increased accountability and transparency and system-wide cost containment measures to generate significant General Fund savings necessary to achieve the balance of overall required reduction of $750 million.

  ▶ *Support of increased accountability and transparency.*

  ▶ *Request that prior to direct service limitations/reductions, DDS identify areas for increased administrative efficiencies and economies of scale within the system infrastructure.*

  ▶ *While not supportive of service and support reductions to individuals with developmental disabilities and their families, the Council recognizes the system will share in the budget burden and any proposals put forth must include a input from the impacted parties, particularly the underserved and people of color, and accurate analysis of the potential impact on the continued ability of persons to increase or retain their independence, productivity, self-direction and inclusion.*

Developmental Centers

- The Department will pursue additional federal funds for treatment services provided to individuals residing in the secure facility at Porterville Developmental Center. It is anticipated this will result in General Fund savings of $10 million in 2011-12.

  ▶ *Support*

- The capital outlay budget includes $2.0 million General Fund to design and install automatic fire sprinklers in 13 buildings that house Nursing Facility and General Acute Care consumers at the Fairview, Porterville and Sonoma Developmental Centers.

  ► *Support*

- Budget proposes the reappropriation of funding for an addressable fire alarm system, already approved by the Legislature, in consumer utilized buildings at Fairview Developmental Center. This project continues to be a critical safety improvement, licensing and code compliance need for Fairview's consumers, staff, and visitors.

  ► *Support*

- "...construction phase for a new piping system, already approved by the Legislature, to supply additional oxygen, medical air and suction, and a new oxygen storage tank at the Johnson/Ordahl building at Sonoma Developmental Center.

  ► *Support*

DEPARTMENT OF SOCIAL SERVICES (CDSS)

Supplemental Security Income/State supplementary Payment (SSI/SSP)

- The Governor's Budget proposal would reduce monthly SSP grants for individuals to the federally required minimum payment standard. Under this proposal, the maximum monthly SSI/SSP cash grant for individuals would be reduced by $15 per month (from $845 to $830), beginning June 1, 2011. SSP grants for couples were previously reduced to the federal minimum in November 2009.

  ► *Oppose. This decrease will negatively impact the ability of persons to live in the community. While individuals with developmental disabilities, served by the regional center system, will have their reduction backfilled (see proposal under DDS), others on SSI/SSP will not.*

In-Home Supportive Services (IHSS)

- Budget proposed an 8.4percent reduction to assessed hours for all IHSS recipients for General Fund savings of $127.5 million in 2011-12. This proposal, combined with the 3.6percent reduction enacted in 2010-11, would bring the total across-the-board reduction in assessed hours for IHSS recipients to 12 percent.

  ► *Oppose increase of 8.4 % across-the-board reduction and substitute an individualized review and, if appropriate, reduction in assessed hours.*

- Proposal would eliminate domestic and related services (which include housework, shopping for food, meal preparation and cleanup, and laundry) for consumers living with their provider. IHSS applicants/recipients who have a need for domestic and/or related services that cannot be met in common due to a medically verified condition of other members of the shared living arrangement could be authorized hours for any of these services that meet the need assessment metrics. Minor recipients are living with their parent(s), the need is being met in common; hence, the need for domestic and related service hours would no longer be allowed. The parent would be presumed available to perform these tasks unless the parent could provide medical verification of his/her inability to do so.

  ► *Oppose*

- Requires the provision of IHSS services to be conditioned upon a physician's written certification that personal care services are necessary to prevent out-of-home care.

  ► *Oppose. IHSS is not a medical model program and physicians are not trained to assess a person's ability to live in the community. Continued certification of need for services should be completed by an entity that is qualified and uses a standardized assessment tool and process throughout California.*

DEPARTMENT OF AGING (CDA)

- Multipurpose Senior Centers (MSSP) provide case management services for elderly clients who qualify for placement in a nursing facility but who wish to remain in the community. This proposal would eliminate these services for a savings of $19.9 million General Fund in 2011-12.

  ▶ Oppose. *Closure of MSSP sites are designed to keep people included in communities and such inclusion is less costly to the taxpayers that placement in skilled nursing facilities.*

DEPARTMENT OF HEALTH CARE SERVICES (DHCS)

▶ *All efforts must be made to access and maximize other sources of income including but not limited to:*

- *Issuing directions to counties regarding the use of state and local funds for Medi-Cal share of costs for California Children's Services (CCS).*
- *Require that the Consolidated Omnibus Budget Reconciliation Act (COBRA) notices be issued in California to provide information about the Health Insurance Premium Payment Program (HIPP) for coverage of premium costs of COBRA benefits; and information that receiving an extension of the 11-month disability extension does not require a person to quality for Social Security benefits.*
- *Examine other states' successes in ensuring that costs of long-term care are not prematurely shifted from Medicare to Medi-Cal.*
- *Seek payments by health plans to cover their obligations to children with disabilities covered under their parent's group plans.*
- *Require private insurance plans to cover the full cost of wheelchairs and other durable medical equipment.*
- *Actively promote the coverage of children under 26 years old on their parent's private insurance.*

- *Pursue federal financial participation for the costs of veterans pharmacy benefits.*

Medi-Cal

- Proposal establishes utilization controls at a maximum annual benefit dollar on hearing aids ($1,510), durable medical equipment ($1,604), incontinence supplies ($1,659), urological supplies ($6,435), and wound care ($391), limits prescriptions (except life-saving drugs) to six per month, and limits the number of doctor visits to ten per year.

  ▶ *Oppose. Decisions about the level of medical services required should be made on an individualized basis. The potential impact of a formula could be to jeopardize the health and safety of individuals with developmental disabilities.*

- Co-payments would become mandatory. This proposal includes a $5 co-payment on physician, clinic, dental, and pharmacy services ($3 on lower cost preferred drugs) for savings of $294.4 million in 2011-12.

  ▶ *Oppose. However if adopted, request a process be established to grant exceptions from the increased level or entire co-pay requirement if the co-pay will reduce access to necessary medical care services. With the decrease in SSI/SSP, less cash is available to people who access both publically funded supports, thus the impact of coupling these proposals is results in a disproportionate reduction to this population as compared to other publically funded services.*

- Budget proposal would also eliminate the optional Adult Day Health Care program for savings of $1.5 million in 2010-11 and $176.6 million in 2011-12.

  ▶ *Oppose. This will impact people with developmental disabilities and their ability to remain included in their communities. It also shifts the burden to the Department of Developmental Services for meeting these people's needs without any fiscal relief to DDS.*

- Budget proposes to reduce provider payments by 10 percent for physicians, pharmacy, clinics, medical transportation, home health, Adult Day Health Care, certain hospitals, and nursing facilities.

  ▶ *To the extent that this would reduce the availability of medical care to persons with developmental disabilities, the proposal would add to the disproportionate share of reductions they would experience.*

- The Budget proposes to use $1 billion in Proposition 10 funds to fund Medi-Cal services for children through age five.

  ▶ *Support*

- The Budget proposes to extend the fee through June 31, 2011, which will save $160 million in Medical. Fee revenue is used to leverage federal funding to provide supplemental payments to hospitals for the provision of Medi-Cal services and to offset General Fund costs to a lesser degree.

  ▶ *Support*

An act to add Section 14131.05 to the Welfare and Institutions Code, relating to Medi-Cal, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Medi-Cal: selected optional benefits: benefit caps.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services, under which qualified low-income persons are provided with health care services. The Medi-Cal program is partially governed and funded by federal Medicaid Program provisions.

This bill would, notwithstanding prescribed provisions of law, and with certain exceptions, establish an annual per beneficiary benefit cap amount, as defined, for specified optional benefits. The bill would provide that certain Medi-Cal beneficiaries would be exempt from its provisions. This bill would require that it be implemented on the first day of the first calendar month following 210 days after its effective date, and only to the extent permitted by federal law.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14131.05 is added to the Welfare and Institutions Code, to read:

14131.05. (a) Notwithstanding any other provision of this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14590), in order to implement changes in the level of funding for health care services, specific optional benefits are subject to per beneficiary benefit cap amounts under the Medi-Cal program.

(b) For the purposes of this section, "benefit cap amount" means the maximum amount of Medi-Cal coverage for specified optional benefits in subdivision (c), for each beneficiary, for each fiscal year.

(c) The following optional benefits are subject to a benefit cap amount under the Medi-Cal program:

(1) Hearing aid benefits are subject to a benefit cap amount of one thousand five hundred ten dollars ($1,510).

(2) Durable medical equipment benefits are subject to a benefit cap amount of one thousand six hundred four dollars ($1,604).

(3) Select disposable medical supply benefits are subject to the following benefit cap amounts:

(A) Incontinence medical supplies are subject to a benefit cap amount of one thousand six hundred fifty-nine dollars ($1,659).

(B) Urological medical supplies are subject to a benefit cap amount of six thousand four hundred thirty-five dollars ($6,435).

(C) Wound care medical supplies are subject to a benefit cap amount of three hundred ninety-one dollars ($391).

(d) The benefit cap amounts in subdivision (c) do not apply to the following items:

(1) Compressed oxygen equipment and supplies.

(2) Respiratory equipment and supplies.

(3) Tracheostomy medical supplies.

(4) Ostomy medical supplies.

(5) Diabetic medical supplies.

(6) Respiratory medical supplies.

(7) Infusion supplies.

(8) Disposable gloves.

(9) Medical supplies categorized as "miscellaneous" on the Medi-Cal list of covered medical supplies.

(e) Pregnancy-related benefits and benefits for the treatment of other conditions that might complicate the pregnancy are not subject to the benefit cap amounts in subdivision (c).

(f) The benefit cap amounts in subdivision (c) do not apply to the following:

(1) Beneficiaries under the Early and Periodic Screening Diagnosis and Treatment Program.

(2) Beneficiaries receiving long-term care in a nursing facility that is both of the following:

(A) A skilled nursing facility or intermediate care facility as defined in subdivisions (c) and (d) of Section 1250 of the Health and Safety Code.

(B) A licensed nursing facility pursuant to subdivision (k) of Section 1250 of the Health and Safety Code.

(g) This section shall be implemented only to the extent permitted by federal law.

(h) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department may implement the provisions of this section by means of all-county letters, provider bulletins, or similar instructions, without taking further regulatory action.

(i) This section shall be implemented on the first day of the first calendar month following 210 days after the effective date of this section.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary for implementation of the Budget Act of 2011, it is necessary that this act take effect immediately.

An act to add Section 12200.03 to the Welfare and Institutions Code, relating to public social services, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Public social services: SSI/SSP: maximum aid payments.

Existing law provides for the State Supplementary Program for the Aged, Blind and Disabled (SSP), which requires the State Department of Social Services to contract with the United States Secretary of Health and Human Services to make payments to SSP recipients to supplement Supplemental Security Income (SSI) payments made available pursuant to the federal Social Security Act. State payment levels for SSI/SSP recipients are established in accordance with prescribed requirements. Existing law also establishes the Medi-Cal program, which is partially governed and funded pursuant to the federal Medicaid Program.

This bill would require SSI/SSP rates for individuals to be reduced to equal the minimum amount required by the federal Social Security Act in order to maintain the state's eligibility for federal Medicaid funding, subject to prescribed exceptions. The

bill would make this reduction effective on the first day of the first month following 90 days after the effective date of the bill.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 12200.03 is added to the Welfare and Institutions Code, to read:

12200.03. Notwithstanding any other law, on the first day of the first month following 90 days after the effective date of the act that adds this section, the maximum aid payment for an individual, as specified in Section 12200, except subdivisions (e), (g), and (h) of that section, shall be reduced to equal the minimum amount required by the federal Social Security Act in order to maintain eligibility for federal funding under Title XIX of the federal Social Security Act, contained in Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary for implementation of the Budget Act of 2011, it is necessary that this act take effect immediately.

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An act to add Article 6 (commencing with Section 14589) to Chapter 8.7 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to Medi-Cal, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Medi-Cal: adult day health care.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Adult Day Health Medi-Cal Law establishes adult day health care services as a Medi-Cal benefit for Medi-Cal beneficiaries who meet certain criteria.

This bill would provide, to the extent permitted by federal law, that notwithstanding existing law, adult day health care be excluded from coverage under the Medi-Cal program. This bill would provide that this provision shall be implemented on the first day of the first calendar month following 90 days after the effective date of the bill.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Article 6 (commencing with Section 14589) is added to Chapter 8.7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 6. Cessation of Adult Day Health Care

14589. (a) Notwithstanding any other provision of law related to the Medi-Cal program or to adult day health care, in order to implement changes in the level of funding for health care services, adult day health care is excluded from coverage under the Medi-Cal program.

(b) This section shall only be implemented to the extent permitted by federal law.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the provisions of this section by means of all-county letters, provider bulletins, or similar instructions, without taking further regulatory action.

(d) This section shall be implemented on the first day of the first calendar month following 90 days after the effective date of the act that adds this section.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary for implementation of the Budget Act of 2011, it is necessary that this act take effect immediately.

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An act to add Section 4629.5 to the Welfare and Institutions Code, relating to developmental services, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Regional center contracts: direct services.

Under existing law, the Lanterman Developmental Disabilities Services Act, the State Department of Developmental Services is responsible for providing various services and supports to individuals with developmental disabilities, and for ensuring the appropriateness and quality of those services and supports. Under existing law, regional centers contract with the department, as well as other service providers, to provide services and supports to persons with developmental disabilities.

This bill would require, notwithstanding any other provision of law, all regional center contracts with the department, and all regional center contracts or agreements with service providers, to require that at least 85% of regional center funds be spent on direct services, as defined. The bill would specifically exclude designated administrative costs from being included in the definition of direct services. This bill would require service providers and contractors, upon request, to provide regional

centers with access to specified information pertaining to the service providers' and contractors' negotiated rates.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 4629.5 is added to the Welfare and Institutions Code, to read:

4629.5. (a) Notwithstanding any other provision of law, all regional center contracts or agreements with service providers in which rates are determined through negotiations between the regional center and the service provider shall expressly require that at least 85 percent of regional center funds be spent on direct services. For purposes of this subdivision, direct service expenditures are those costs immediately associated with the services being offered by the provider. Funds spent on direct services shall not include any administrative costs. Administrative costs include, but are not limited to, any of the following:

(1) Salaries, wages, and employee benefits for managerial personnel whose primary purpose is the administrative management of the entity, including, but not limited to, directors and chief executive officers.

(2) Salaries, wages, and benefits of other nondirect service employees, including, but not limited to, payroll management, personnel functions, accounting, budgeting, auditing, and facility management.

(3) Facility operation costs, except those immediately associated with direct services, as defined in this subdivision.

(4) Maintenance and repair.

(5) Data processing and computer services.

(6) Contract and procurement activities.

(7) Training.

(8) Nondirect service travel.

(9) Licenses.

(10) Taxes.

(11) Interest.

(12) Insurance.

(13) Depreciation.

(14) General administrative expenses.

(b) Notwithstanding any other provision of law, all contracts between the department and the regional centers shall require that at least 85 percent of all funds appropriated through the regional center's operations budget shall be spent on direct services. For purposes of this subdivision, "direct services" includes service coordination, assessment and diagnosis, monitoring of consumer services, and clinical services. Funds spent on direct services shall not include any administrative costs. For purposes of this subdivision, administrative costs include, but are not limited to, any of the following:

(1) Salaries, wages, and employee benefits for managerial personnel whose primary purpose is the administrative management of the regional center, including, but not limited to, directors and chief executive officers.

(2) Salaries, wages, and benefits of other nondirect service employees, including, but not limited to, payroll management, personnel functions, accounting, budgeting, auditing, and facility management.

(3) Facility operation costs, except those immediately associated with direct services, as defined in this subdivision.

(4) Maintenance and repair.

(5) Data processing and computer services.

(6) Contract and procurement activities.

(7) Training.

(8) Nondirect service travel.

(9) Licenses.

(10) Taxes.

(11) Interest.

(12) Insurance.

(13) Depreciation.

(14) General administrative expenses.

(c) Consistent with subdivision (a), service providers and contractors, upon request, shall provide regional centers with access to any books, documents, papers, computerized data, source documents, consumer records, or other records pertaining to the service providers' and contractors' negotiated rates.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary to implement the Budget Act of 2011, it is necessary for this act to take effect immediately.

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An act to amend Section 4639 of, and to add Section 4652.5 to, the Welfare and Institutions Code, relating to developmental services, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Developmental services: audits.

Under existing law, the Lanterman Developmental Disabilities Services Act, the State Department of Developmental Services is authorized to contract with regional centers to provide support and services to individuals with developmental disabilities. Existing law requires the governing board of a regional center to annually contract with an independent accounting firm for an audited financial statement.

This bill would prohibit the audit of a regional center from being completed by the same accounting firm more than 5 times in every 10 years.

Under existing law, regional centers purchase needed services for individuals with developmental disabilities through approved service providers or arrange for their provision through other publicly funded agencies.

This bill would require an entity receiving payments from one or more regional centers, except for state and local governmental agencies, the University of California,

or the California State University, to contract with an independent accounting firm for an audit or review of its financial statements, as specified. The bill would require regional centers to review and require resolution by the entity for issues identified in the report that have a direct or indirect impact on regional center services and to take appropriate action, up to termination of vendorization, for lack of adequate resolution of issues. The bill would require a regional center to notify the department of all qualified opinion reports or reports noting significant issues that directly or indirectly impact regional center services within 30 days after receipt. The bill would make related changes.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 4639 of the Welfare and Institutions Code is amended to read:

4639. (a) The governing board of a regional center shall annually contract with an independent accounting firm for an audited financial statement. The audit report and accompanying management letter shall be reviewed and approved by the regional center board and submitted to the department within 60 days of completion and before April 1 of each year. Upon submission to the department, the audit report and accompanying management letter shall be made available to the public by the regional center. It is the intent of the Legislature that no additional funds be appropriated for this purpose.

(b) The audit specified in subdivision (a) shall not be completed by the same accounting firm more than five times in every 10 years.

SEC. 2. Section 4652.5 is added to the Welfare and Institutions Code, to read:

4652.5. (a) (1) An entity receiving payments from one or more regional centers shall contract with an independent accounting firm for an audit or review of its financial statements subject to all of the following:

(A) When the amount received from the regional center or regional centers during the entity's fiscal year is more than or equal to two hundred and fifty thousand dollars ($250,000) but less than five hundred thousand dollars ($500,000), the entity shall obtain an independent audit or independent review of its financial statements for the period. Consistent with Subchapter 21 (commencing with Section 58800) of Title 17

of the California Code of Regulations, this subdivision shall also apply to work activity program providers receiving less than two hundred fifty thousand dollars ($250,000).

(B) When the amount received from the regional center or regional centers during the entity's fiscal year is equal to or more than five hundred thousand dollars ($500,000), the entity shall obtain an independent audit of its financial statements for the period.

(2) This requirement does not apply to payments made using usual and customary rates, as defined by Title 17 of the California Code of Regulations, for services provided by regional centers.

(3) This requirement does not apply to state and local governmental agencies, the University of California, or the California State University.

(b) An entity subject to subdivision (a) shall provide copies of the independent audit or independent review report required by subdivision (a), and accompanying management letters, to the vendoring regional center within 30 days after completion of the audit or review.

(c) Regional centers receiving the audit or review reports required by subdivision (b) shall review and require resolution by the entity for issues identified in the report that have a direct or indirect impact on regional center services. Regional centers shall take appropriate action, up to termination of vendorization, for lack of adequate resolution of issues.

(d) Regional centers shall notify the department of all qualified opinion reports or reports noting significant issues that directly or indirectly impact regional center services within 30 days after receipt. Notification shall include a plan for resolution of issues.

(e) For purposes of this section, an independent review of financial statements must be performed by an independent accounting firm and shall cover, at a minimum, all of the following:

(1) An inquiry as to the entity's accounting principles and practices and methods used in applying them.

(2) An inquiry as to the entity's procedures for recording, classifying, and summarizing transactions and accumulating information.

(3) Analytical procedures designed to identify relationships or items that appear to be unusual.

(4) An inquiry about budgetary actions taken at meetings of the board of directors or other comparable meetings.

(5) An inquiry about whether the financial statements have been properly prepared in conformity with Generally Accepted Accounting Principles and whether any events subsequent to the date of the financial statements would have a material effect on the statements under review.

(6) Working papers prepared in connection with a review of financial statements describing the items covered as well as any unusual items, including their disposition.

(f) For purposes of this section, an independent review report shall cover, at a minimum, all of the following:

(1) Certification that the review was performed in accordance with standards established by the American Institute of Certified Public Accountants.

(2) Certification that the statements are the representations of management.

(3) Certification that the review consisted of inquiries and analytical procedures that are lesser in scope than those of an audit.

(4) Certification that the accountant is not aware of any material modifications that need to be made to the statements for them to be in conformity with Generally Accepted Accounting Principles.

(g) The department shall not consider a request for adjustments to rates submitted in accordance with Title 17 of the California Code of Regulations by an entity receiving payments from one or more regional centers solely to fund either anticipated or unanticipated changes required to comply with this section.

SEC. 3. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make necessary changes for the implementation of the Budget Act of 2011, it is necessary that this act take effect immediately.

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An act to amend Section 14133.22 of the Welfare and Institutions Code, relating to Medi-Cal, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Medi-Cal: prescription drugs.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law limits the number of prescription drugs that a Medi-Cal beneficiary may receive under the Medi-Cal program to 6 per month, unless prior authorization is received. Existing law provides an exception from the limit on prescription drugs for patients receiving care in a nursing facility and for drugs for family planning.

This bill would remove the prior authorization requirement and, instead, provide an exception from the limit on prescription drugs for patients receiving care in a nursing facility, patients receiving pregnancy-related services, children under 21 years of age, and any drug specifically exempted by the department, as provided.

This bill would require the department to seek any necessary federal approvals for the implementation of these provisions. This bill would provide that these provisions shall become operative on October 1, 2011, or on the date the department secures all necessary federal approvals to implement these provisions, whichever is later.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14133.22 of the Welfare and Institutions Code is amended to read:

14133.22. (a) (1) Prescribed drugs shall be limited to no more than six per month, unless prior authorization is obtained.

~~(b)~~

(2) The limit in ~~subdivision (a)~~ paragraph (1) shall not apply to patients receiving care in a nursing facility.

~~(c)~~

(3) The limit in ~~subdivision (a)~~ paragraph (1) shall not apply to drugs for family planning.

~~(d)~~

(4) The department may issue Medi-Cal cards that contain labels for prescribed drugs to implement this section.

~~(e)~~

(5) In carrying out this ~~section~~ subdivision, the department may contract either directly, or through the fiscal intermediary, for pharmacy consultant staff necessary to accomplish the treatment authorization request reviews.

(b) Subdivision (a) shall become inoperative on October 1, 2011, or on the date the department secures all necessary federal approvals to implement subdivision (c), whichever is later.

(c) (1) Prescribed drugs shall be limited to no more than six per month.

(2) The limit in paragraph (1) shall not apply to the following:

(A) Patients receiving care in a nursing facility, patients receiving pregnancy-related services, or children under 21 years of age.

(B) Any drug specifically exempted from paragraph (1) by the department. Any exemption of a drug shall be established by the department in accordance with the purposes of the Medi-Cal program and shall be subject to utilization controls.

(d) Subdivision (c) shall become operative on October 1, 2011, or on the date the department secures all necessary federal approvals to implement subdivision (c), whichever is later.

(e) The director shall implement subdivision (c) in a manner that is consistent with federal Medicaid law and regulations. The director shall seek any necessary federal approvals for the implementation of subdivision (c). Subdivision (c) shall be implemented only to the extent that federal approval is obtained.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement subdivision (c) by means of all-county letters, provider bulletins, policy letters, or similar instructions, without taking regulatory action.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary for implementation of the Budget Act of 2011, it is necessary that this act take effect immediately.

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An act to amend Sections 4626 and 4627 of, and to add Section 4626.5 to, the Welfare and Institutions Code, relating to developmental services, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Regional centers: conflicts of interest.

Existing law, the Lanterman Developmental Disabilities Services Act, requires the State Department of Developmental Services to enter into contracts with private nonprofit corporations to operate regional centers for the provision of community services and support for persons with developmental disabilities and their families, including, but not limited to, residential placement. Existing law sets forth the duties of the regional centers, including, but not limited to, development of individual program plans, the purchase of needed services to implement the plan, and the monitoring of services.

Existing law requires the department to adopt and enforce conflict-of-interest regulations to insure that members of the governing board, program policy committee, and employees of the regional center make decisions with respect to the regional centers that are in the best interests of consumers and families.

This bill would, in addition, require that the department adopt emergency and other regulations to establish standard conflict-of-interest reporting requirements to require regional center board members, directors, and identified employees to complete and file conflict-of-interest statements. The bill would make conforming changes and would delete provisions permitting persons who served on a board or program policy committee on January 1, 1982, to continue to serve. The bill would require each regional center to submit a conflict-of-interest policy to the department by July 1, 2011, and to post the policy on its Internet Web site by August 1, 2011.

By requiring that the conflict-of-interest statements be signed under penalty of perjury, this bill would impose a state-mandated local program by changing the definition of an existing crime.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 4626 of the Welfare and Institutions Code is amended to read:

4626. (a) ~~In~~ The department shall give a very high priority to ensuring that regional center board members and employees act in the course of their duties solely in the best interest of the regional center consumers and their families without regard to the interests of any other organization with which they are associated or persons with whom they are related. Board members, employees, and others acting on the regional center's behalf, as defined in regulations issued by the department, shall be free from conflicts of interest that could adversely influence their judgment, objectivity, or loyalty to the regional center, its consumers, or its mission.

(b) In order to prevent potential conflicts of interest, no member of the governing board or member of the program policy committee of a regional center shall be any of the following:

(1) An employee of the State Department of Developmental Services or any state or local agency ~~which~~ that provides services to a regional center ~~client~~ consumer, if employed in a capacity which includes administrative or policymaking responsibility, or responsibility for the regulation of the regional center.

(2) An employee or a member of the state council or an area board.

(3) Except as otherwise provided in subdivision (h) of Section 4622, an employee or member of the governing board of any entity from which the regional center purchases ~~client~~ consumer services.

(4) Any person who has a financial interest, as defined in Section 87103 of the Government Code, in regional center operations, except as a consumer of regional center services.

~~(b) Notwithstanding paragraph (1) of subdivision (a), members serving on the governing board or program policy committee of a regional center on January 1, 1982, may continue to serve on the board or committee until the expiration of their term as defined in subdivision (f) of Section 4622. Notwithstanding any other provision of this section, members serving on the governing board or program policy committee of a regional center on January 1, 1982, may continue to serve on the board or committee until the expiration of their current term. Changes in the composition of the board or committee required by amendments to this section that are operative on January 1, 1982, shall apply only to subsequent vacancies on the board or committee.~~

(c) The department shall ensure that no regional center employee or board member has a conflict of interest with an entity that receives regional center funding, including, but not limited to, a nonprofit housing organization and an organization qualified under Section 501(c)(3) of the Internal Revenue Code, that actively functions in a supporting relationship to the regional center.

(d) The department shall develop and publish a standard conflict-of-interest reporting statement. The conflict-of-interest statement shall be completed by each regional center governing board member and each regional center employee specified in regulations, including, at a minimum, the executive director, every administrator, every program director, and every employee who has decisionmaking or policymaking authority or authority to obligate the regional center's resources.

(e) Every new regional center governing board member and regional center executive director shall complete and file the conflict-of-interest statement described in subdivision (d) with his or her respective governing board within 30 days of being selected, appointed, or elected. Every new regional center employee referenced in subdivision (d) and every current regional center employee referenced in subdivision (d) accepting a new position within the regional center shall complete and file the conflict-of-interest statement with his or her respective regional center within 30 days of assuming the position.

(f) Every regional center board member and regional center employee referenced in subdivision (d) shall complete and file the conflict-of-interest statement by August 1 of each year.

(g) Every regional center board member and regional center employee referenced in subdivision (d) shall complete and file a subsequent conflict-of-interest statement upon any change in status that creates a potential or present conflict of interest. For the purposes of this subdivision, a change in status includes, but is not limited to, a change in financial interests, legal commitment, regional center or board position or duties, or both, or outside position or duties, or both, whether compensated or not.

(h) The governing board shall submit a copy of the completed conflict-of-interest statements of the governing board members and the regional center executive director to the department within 10 days of receipt of the statements.

(i) All conflict-of-interest statements required pursuant to this section or Sections 4626.5 and 4627 shall be signed under penalty of perjury.

(j) The director of the regional center shall review the conflict-of-interest statement of each regional center employee referenced in subdivision (d) within 10 days of receipt of the statement. If a potential or present conflict of interest is identified for a regional center employee that cannot be eliminated, the regional center shall, within 30 days of receipt of the statement, submit to the department, the state council, and the respective area board, a copy of the conflict-of-interest statement and a plan that proposes mitigation measures, including timeframes and actions the regional center or the employee, or both, will take to mitigate the conflict of interest.

(k) The department and the regional center governing board shall review the conflict-of-interest statement of the regional center executive director and each regional center board member to ensure that no conflict of interests exist. If a present or potential conflict of interest is identified for a regional center director or a board member that cannot be eliminated, the regional center governing board shall, within 30 days of receipt of the statement, submit to the department, the state council, and the respective area board, a copy of the conflict-of-interest statement and a plan that proposes mitigation measures, including timeframes and actions the regional center governing board or the individual, or both, will take to mitigate the conflict of interest.

SEC. 2. Section 4626.5 is added to the Welfare and Institutions Code, to read:

4626.5. Each regional center shall submit a conflict-of-interest policy to the department by July 1, 2011, and shall post the policy on its Internet Web site by August 1, 2011. The policy shall do, or comply with, all of the following:

(a) Contain the elements of this section and be consistent with applicable law.

(b) Define conflicts of interest.

(c) Identify positions within the regional center required to complete and file a conflict-of-interest statement.

(d) Facilitate disclosure of information to identify conflicts of interest.

(e) Require candidates for nomination, election, or appointment to a regional center board, and applicants for regional center director to disclose any potential or present conflicts of interest prior to being appointed, elected, or confirmed for hire by the regional center or the regional center governing board.

(f) Require the regional center and its governing board to regularly and consistently monitor and enforce compliance with its conflict-of-interest policy.

SEC. 3. Section 4627 of the Welfare and Institutions Code is amended to read:

4627. (a) The director of the department shall ~~promulgate~~ adopt and enforce ~~conflict of interest~~ conflict-of-interest regulations to ~~insure~~ ensure that members of the governing board, program policy committee, and employees of the regional center make decisions with respect to the regional centers that are in the best interests of the center's ~~clients~~ consumers and families.

(b) The department shall monitor and ensure the regional centers' compliance with this section and Sections 4626 and 4626.5. Failure to disclose information pursuant to these sections and related regulations may be considered grounds for removal from the board or for termination of employment.

(c) The department shall adopt regulations to develop standard conflict-of-interest reporting requirements.

(d) The department shall adopt emergency regulations to implement this section and Sections 4626 and 4626.5 by _____. The adoption, amendment, repeal, or

readoption of a regulation authorized by this section is deemed to be necessary for the immediate preservation of the public peace, health and safety, or general welfare, for purposes of Sections 11346.1 and 11349.9 of the Government Code, and the department is hereby exempted from that requirement. For purposes of subdivision (e) of Section 11346.1 of the Government Code, the 120-day period, as applicable to the effective period of an emergency regulatory action and submission of specified materials to the Office of Administrative Law, is hereby extended to 180 days.

(e) The department shall adopt regulations to implement the terms of subdivision (d) through the regular rulemaking process pursuant to Sections 11346 and 11349.1 of the Government Code within 18 months of the adoption of emergency regulations pursuant to subdivision (d).

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

SEC. 5. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary for implementation of the Budget Act of 2011, it is necessary that this act take effect immediately.

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An act to add Section 14131.07 to the Welfare and Institutions Code, relating to Medi-Cal, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Medi-Cal: physician office and clinic visits.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Under existing law, outpatient services provided by a physician are a covered benefit under the Medi-Cal program, subject to utilization controls.

This bill would, to the extent permitted by federal law, limit physician office and clinic visits that are a covered benefit under the Medi-Cal program, with specified exceptions, to 10 visits per beneficiary per fiscal year. This bill would require these provisions to be implemented on the first day of the first calendar month following 180 days after the effective date of the bill.

This bill would declare that it is to take effect immediately as an urgency statute.

18192

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14131.07 is added to the Welfare and Institutions Code, to read:

14131.07. (a) Notwithstanding any other provision of this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14590), in order to implement the changes in the level of funding for health care services, the total number of physician office and clinic visits for physician services provided by a physician, or under the direction of a physician, that are a covered benefit under the Medi-Cal program shall be limited to 10 visits per beneficiary per fiscal year. For purposes of this limit, a visit shall include physician services provided at any federally qualified health center, rural health clinic, community clinic, outpatient clinic, and hospital outpatient department.

(b) Any pregnancy-related visit, or any visit for the treatment of any other condition that might complicate a pregnancy, shall not be subject to the limit provided in subdivision (a).

(c) The limit on physician office and clinic visits provided in subdivision (a) shall not apply to any of the following:

(1) A beneficiary under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

(2) A beneficiary receiving long-term care in a nursing facility that is both of the following:

(A) A skilled nursing facility or intermediate care facility as defined in subdivisions (c) and (d), respectively, of Section 1250 of the Health and Safety Code.

(B) Licensed pursuant to subdivision (k) of Section 1250 of the Health and Safety Code.

(d) This section shall be implemented only to the extent permitted by federal law.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of all-county letters, provider bulletins, or similar instructions, without taking regulatory action.

(f) This section shall be implemented on the first day of the first calendar month following 180 days after the effective date of the act that added this section.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary for implementation of the Budget Act of 2011, it is necessary that this act take effect immediately.

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16952

An act to amend Section 14105.191 of, and to add Section 14105.192 to, the Welfare and Institutions Code, relating to Medi-Cal, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Medi-Cal: provider payments.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law requires, except as otherwise provided, Medi-Cal provider payments to be reduced by 1% or 5%, as specified, for dates of service on and after March 1, 2009. Existing law also requires provider payments for specified non-Medi-Cal programs to be reduced by 1% for dates of on and after March 1, 2009.

This bill would provide that these provisions shall not apply to dates of service on and after June 1, 2011. This bill also would require, except as otherwise provided, that Medi-Cal provider payments be reduced by 10%, as specified, for dates of service on and after June 1, 2011. The bill would require that specified non-Medi-Cal program

payments also be reduced by 10% for dates of service on and after June 1, 2011. This bill would require the Director of Health Care Services to seek any necessary federal approvals for the implementation of this payment reduction and would require that the payment reduction only be implemented if the director determines that the payment reduction will comply with applicable federal Medicaid requirements and that federal financial participation is available. To the extent that federal financial participation is not available or the rates do not comply with federal Medicaid requirements, this bill would authorize the director to elect not to implement the rates or adjust the rates as necessary to comply with federal Medicaid requirements.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14105.191 of the Welfare and Institutions Code is amended to read:

14105.191. (a) Notwithstanding any other provision of law, in order to implement changes in the level of funding for health care services, the director shall reduce provider payments, as specified in this section.

(b) (1) Except as otherwise provided in this section, payments shall be reduced by 1 percent for Medi-Cal fee-for-service benefits for dates of service on and after March 1, 2009.

(2) Except as provided in subdivision (d), for dates of service on and after March 1, 2009, payments to the following classes of providers shall be reduced by 5 percent for Medi-Cal fee-for-service benefits:

(A) Intermediate care facilities, excluding those facilities identified in paragraph (5) of subdivision (d). For purposes of this section, "intermediate care facility" has the same meaning as defined in Section 51118 of Title 22 of the California Code of Regulations.

(B) Skilled nursing facilities that are distinct parts of general acute care hospitals. For purposes of this section, "distinct part" has the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(C) Rural swing-bed facilities.

(D) Subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this subparagraph, "subacute care unit" has the same meaning as defined in Section 51215.5 of Title 22 of the California Code of Regulations.

(E) Pediatric subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this subparagraph, "pediatric subacute care unit" has the same meaning as defined in Section 51215.8 of Title 22 of the California Code of Regulations.

(F) Adult day health care centers.

(3) Except as provided in subdivision (d), for dates of service on and after March 1, 2009, Medi-Cal fee-for-service payments to pharmacies shall be reduced by 5 percent.

(4) Except as provided in subdivision (d), payments shall be reduced by 1 percent for non-Medi-Cal programs described in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after March 1, 2009.

(5) For managed health care plans that contract with the department pursuant to this chapter, Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14590), payments shall be reduced by the actuarial equivalent amount of the payment reductions specified in this subdivision pursuant to contract amendments or change orders effective on July 1, 2008, or thereafter.

(c) Notwithstanding any other provision of this section, payments to hospitals that are not under contract with the State Department of Health Care Services pursuant to Article 2.6 (commencing with Section 14081) for inpatient hospital services provided to Medi-Cal beneficiaries and that are subject to Section 14166.245 shall be governed by that section.

(d) To the extent applicable, the services, facilities, and payments listed in this subdivision shall be exempt from the payment reductions specified in subdivision (b):

(1) Acute hospital inpatient services that are paid under contracts pursuant to Article 2.6 (commencing with Section 14081).

(2) Federally qualified health center services, including those facilities deemed to have federally qualified health center status pursuant to a waiver pursuant to ~~subsection (a) of Section 1115~~ Section 1115(a) of the federal Social Security Act (42 U.S.C. Sec. 1315(a)).

(3) Rural health clinic services.

(4) Skilled nursing facilities licensed pursuant to subdivision (c) of Section 1250 of the Health and Safety Code other than those specified in paragraph (2) of subdivision (b).

(5) Intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, or facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14495.10.

(6) Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services.

(7) Hospice services.

(8) Contract services, as designated by the director pursuant to subdivision (g).

(9) Payments to providers to the extent that the payments are funded by means of a certified public expenditure or an intergovernmental transfer pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations.

(10) Services pursuant to local assistance contracts and interagency agreements to the extent the funding is not included in the funds appropriated to the department in the annual Budget Act.

(11) Payments to Medi-Cal managed care plans pursuant to Section 4474.5 for services to consumers transitioning from Agnews Developmental Center into the Counties of Alameda, San Mateo, and Santa Clara pursuant to the Plan for the Closure of Agnews Developmental Center.

(12) Breast and cervical cancer treatment provided pursuant to Section 14007.71 and as described in paragraph (3) of subdivision (a) of Section 14105.18 or Article 1.5 (commencing with Section 104160) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code.

(13) The Family Planning, Access, Care, and Treatment (Family PACT) ~~Waiver~~ Program pursuant to ~~Section 14105.18~~ subdivision (aa) of Section 14132.

(14) Small and rural hospitals, as defined in Section 124840 of the Health and Safety Code.

(e) Subject to the exemptions listed in subdivision (d), the payment reductions required by paragraph (1) of subdivision (b) shall apply to the benefits rendered by any provider who may be authorized to bill for provision of the benefit, including, but not limited to, physicians, podiatrists, nurse practitioners, certified nurse midwives, nurse anesthetists, and organized outpatient clinics.

(f) (1) Notwithstanding any other provision of law, Medi-Cal reimbursement rates applicable to the classes of providers identified in paragraph (2) of subdivision (b), for services rendered during the 2009–10 rate year and each rate year thereafter,

shall not exceed the reimbursement rates that were applicable to those classes of providers in the 2008–09 rate year.

(2) In addition to the classes of providers described in paragraph (1), Medi-Cal reimbursement rates applicable to the following classes of facilities for services rendered during the 2009–10 rate year, and each rate year thereafter, shall not exceed the reimbursement rates that were applicable to those facilities and services in the 2008–09 rate year:

(A) Facilities identified in paragraph (5) of subdivision (d).

(B) Freestanding pediatric subacute care units, as defined in Section 51215.8 of Title 22 of the California Code of Regulations.

(3) Paragraphs (1) and (2) shall not apply to providers that are paid pursuant to Article 3.8 (commencing with Section 14126), or to services, facilities, and payments specified in subdivision (d), with the exception of facilities described in paragraph (5) of subdivision (d).

(4) The limitation set forth in this subdivision shall be applied only after the reductions in paragraph (2) of subdivision (b) have been made.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement and administer this section by means of provider bulletins, or similar instructions, without taking regulatory action.

(h) The reductions and limitations described in this section shall apply only to payments for benefits when the General Fund share of the payment is paid with funds

directly appropriated to the department in the annual Budget Act, and shall not apply to payments for benefits paid with funds appropriated to other departments or agencies.

(i) The department shall promptly seek any necessary federal approvals for the implementation of this section. To the extent that federal financial participation is not available with respect to any payment that is reduced or limited pursuant to this section, the director may elect not to implement that reduction or limitation.

(j) This section shall not apply to dates of service on and after June 1, 2011.

SEC. 2. Section 14105.192 is added to the Welfare and Institutions Code, to read:

14105.192. (a) Notwithstanding any other provision of law, in order to implement changes in the level of funding for health care services, the director shall reduce provider payments, as specified in this section.

(b) (1) Except as otherwise provided in this section, payments shall be reduced by 10 percent for Medi-Cal fee-for-service benefits for dates of service on and after June 1, 2011.

(2) For managed health care plans that contract with the department pursuant to this chapter, Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14590), payments shall be reduced by the actuarial equivalent amount of the payment reductions specified in this subdivision pursuant to contract amendments or change orders effective on July 1, 2011, or thereafter.

(c) Notwithstanding any other provision of this section, payments to hospitals that are not under contract with the State Department of Health Care Services pursuant to Article 2.6 (commencing with Section 14081) for inpatient hospital services provided

to Medi-Cal beneficiaries and that are subject to Section 14166.245 shall be governed by that section.

(d) Notwithstanding any other provision of this section, the following shall apply:

(1) Payments to providers that are paid pursuant to Article 3.8 (commencing with Section 14126) shall be governed by that article.

(2) (A) Subject to subparagraph (B), for dates of service on and after June 1, 2011, Medi-Cal reimbursement rates for intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20, as determined by the applicable methodology for setting reimbursement rates for these facilities, shall not exceed the reimbursement rates that were applicable for the 2008–09 rate year.

(B) (i) If Section 14105.07 is added to the Welfare and Institutions Code during the 2011–12 Regular Session of the Legislature, subparagraph (A) shall become inoperative.

(ii) If Section 14105.07 is added to the Welfare and Institutions Code during the 2011–12 Regular Session of the Legislature, then for dates of service on and after June 1, 2011, payments to intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20, shall

be governed by the applicable methodology for setting reimbursement rates for these facilities and by Section 14105.07.

(3) Payments shall be reduced by 10 percent for non-Medi-Cal programs described in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after June 1, 2011.

(e) To the extent applicable, the services, facilities, and payments listed in this subdivision shall be exempt from the payment reductions specified in subdivision (b) as follows:

(1) Acute hospital inpatient services that are paid under contracts pursuant to Article 2.6 (commencing with Section 14081).

(2) Federally qualified health center services, including those facilities deemed to have federally qualified health center status pursuant to a waiver pursuant to Section 1115(a) of the federal Social Security Act (42 U.S.C. Sec. 1315(a)).

(3) Rural health clinic services.

(4) Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services.

(5) Hospice services.

(6) Contract services, as designated by the director pursuant to subdivision (h).

(7) Payments to providers to the extent that the payments are funded by means of a certified public expenditure or an intergovernmental transfer pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations.

(8) Services pursuant to local assistance contracts and interagency agreements to the extent the funding is not included in the funds appropriated to the department in the annual Budget Act.

(9) Breast and cervical cancer treatment provided pursuant to Section 14007.71 and as described in paragraph (3) of subdivision (a) of Section 14105.18 or Article 1.5 (commencing with Section 104160) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code.

(10) The Family Planning, Access, Care, and Treatment (Family PACT) Program pursuant to subdivision (aa) of Section 14132.

(11) Small and rural hospitals, as defined in Section 124840 of the Health and Safety Code.

(f) Subject to the exemptions listed in subdivision (e), the payment reductions required by subdivision (b) shall apply to the benefits rendered by any provider that may be authorized to bill for the service, including, but not limited to, physicians, podiatrists, nurse practitioners, certified nurse midwives, nurse anesthetists, and organized outpatient clinics.

(g) Notwithstanding any other provision of law, for dates of service on and after June 1, 2011, Medi-Cal reimbursement rates applicable to the following classes of providers shall not exceed the reimbursement rates that were applicable to those classes of providers in the 2008–09 rate year, as described in subdivision (f) of Section 14105.191, reduced by 10 percent:

(1) Intermediate care facilities, excluding those facilities identified in paragraph (2) of subdivision (d). For purposes of this section, "intermediate care facility" has the

same meaning as defined in Section 51118 of Title 22 of the California Code of Regulations.

(2) Skilled nursing facilities that are distinct parts of general acute care hospitals. For purposes of this section, "distinct part" has the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(3) Rural swing-bed facilities.

(4) Subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this paragraph, "subacute care unit" has the same meaning as defined in Section 51215.5 of Title 22 of the California Code of Regulations.

(5) Pediatric subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this paragraph, "pediatric subacute care unit" has the same meaning as defined in Section 51215.8 of Title 22 of the California Code of Regulations.

(6) Adult day health care centers.

(7) Freestanding pediatric subacute care units, as defined in Section 51215.8 of Title 22 of the California Code of Regulations.

(h) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement and administer this section by means of provider bulletins, or similar instructions, without taking regulatory action.

(i) The reductions described in this section shall apply only to payments for services when the General Fund share of the payment is paid with funds directly

appropriated to the department in the annual Budget Act, and shall not apply to payments for services paid with funds appropriated to other departments or agencies.

(j) (1) Notwithstanding any other provision of law, the payment reduction provided for in subdivision (b) shall be implemented only if the director determines that the payment reduction complies with applicable federal Medicaid requirements and that federal financial participation is available.

(2) In determining whether federal financial participation is available, the director shall determine whether the rates comply with applicable federal Medicaid requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code.

(3) To the extent that the director determines that the rates do not comply with applicable federal Medicaid requirements or that federal financial participation is not available with respect to any payment that is reduced pursuant to this section, the director retains the discretion to not implement the rates or adjust the rates as necessary to comply with federal Medicaid requirements.

(k) The department shall seek any necessary federal approvals for the implementation of this section.

SEC. 3. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary for implementation of the Budget Act of 2011, it is necessary that this act take effect immediately.

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30965

An act to amend Section 12301 of the Welfare and Institutions Code, relating to public social services, and declaring the urgency thereof, to take effect immediately.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 12301 of the Welfare and Institutions Code is amended to read:

12301. (a) The intent of the Legislature in enacting this article is to provide supplemental or additional services to the social and rehabilitative services in Article 6 (commencing with Section 12250) of this chapter. The Legislature further intends that necessary in-home supportive services shall be provided in a uniform manner in every county based on individual need consistent with this chapter and, for the 1992–93 fiscal year, the appropriation provided for those services in the Budget Act, in the absence of alternative in-home supportive services provided by an able and willing individual or local agency at no cost to the recipient, except as required under Section 12304.5. An able spouse who is available to assist the recipient shall be deemed willing to provide at no cost any services under this article except nonmedical personal services and paramedical services. When a spouse leaves full-time employment or is prevented from obtaining full-time employment because no other suitable provider is available and where the inability of the provider to provide supportive services may result in inappropriate placement or inadequate care, the spouse shall also be paid for accompaniment when needed during necessary travel to health-related appointments and protective supervision.

~~(b) Each county shall be notified of its allocation and projected caseload by July 31 of each fiscal year, or 30 days after the enactment of the Budget Act, whichever occurs later.~~

~~(c) This section shall remain operative until July 1, 1993, and on and after that date, shall remain inoperative until July 1, 1994, at which date, this section shall become operative.~~

(b) (1) An individual who is not the applicant's or recipient's parent or spouse, and who is living in the same household as the applicant or recipient, shall be considered a housemate who is presumed able to provide domestic services, services related to domestic services, heavy cleaning, and yard hazard abatement, unless reliable evidence is provided to the social worker that clearly demonstrates that a physical or mental impairment would prevent the housemate from performing the service. Reliable evidence shall include, but not be limited to, social worker observation or medical certification of the impairment.

(2) An able housemate who is living in the same household as an applicant or recipient shall be presumed available and willing to provide the services specified in paragraph (1) at no cost, and there shall be no payment to any provider for any of the services specified in paragraph (1), except as provided in subdivision (c). The provision of these services shall be presumed to be meeting a common need of all housemates.

(c) (1) A recipient who is receiving any of the services specified in paragraph (1) of subdivision (b), whose service hours have a need of being met in common, shall continue to be authorized to receive payment for that service until his or her next assessment. At that time, the recipient shall be assessed to determine whether it is necessary that any services be authorized for payment, as an exception to paragraph (2) of subdivision (b). Within 30 days following the reassessment, the recipient shall submit medical certification showing that he or she has a specific need for the service

that cannot be provided by a housemate as a need met in common, in order to be authorized for payment for the service.

(2) A recipient whose service hours have been prorated to reflect a need being met in common for any of the services specified in paragraph (1) of subdivision (b) may request authorization for payment for those services, if the recipient provides medical certification demonstrating a specific need for the service that cannot be provided by a housemate as a need met in common. A recipient whose service hours have been prorated to reflect a need being met in common may only request this authorization during his or her next annual reassessment, or if he or she has experienced a change in condition that requires a reassessment.

(3) An applicant may request authorization for payment for any service specified in paragraph (1) of subdivision (b) if the applicant provides medical certification that he or she has a specific need for the service that cannot be provided by a housemate as a need met in common.

(4) The department, in consultation with the State Department of Health Care Services, shall develop a standard form that can be used by a licensed physician or public health nurse to certify that an applicant or recipient has an identified need for one or more of the services listed in paragraph (1) of subdivision (b) and that the service cannot be provided by a housemate as a need met in common.

(d) A county shall provide notice to each recipient who receives a reduction in authorized hours as a result of implementing the shared living arrangement reduction in hours specified in paragraph (1) of subdivision (b). The notice shall include all of the following information:

(1) The amount of authorized hours the recipient received prior to the implementation of the reduction and the amount of hours the recipient is to receive as a result of the reduction.

(2) The reason for the reduction.

(3) A statement that the reduction shall be effective upon the date this section becomes operative.

(4) A statement that the claimant may request a state hearing to appeal the reduction pursuant to this section.

(e) Notwithstanding Section 11004, in any proceeding pursuant to Section 10950 where it has been determined that the sole issue was a reduction in hours required by this section, no aid paid pending the hearing shall be issued.

(f) (1) Notwithstanding the rulemaking provisions of the Administrative Procedure Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement and administer this section through all-county letters or similar instruction from the department until regulations are adopted. The department shall adopt emergency regulations implementing this section no later than July 1, 2012. The department may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the one readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the one

readoption of emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(g) The amendments made by the addition of subdivision (b) to (f), inclusive, to this section by the act that added this subdivision shall become operative on the first day of the first month following 90 days after the effective date of the act that added this subdivision, or July 1, 2011, whichever is later.

SEC. 2. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 3. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary to implement the Budget Act of 2011, it is necessary for this act to take effect immediately.

for payment pursuant to a scheduled needs reassessment, due to a change in condition, or if the recipient provides medical certification demonstrating a specific need for a service that cannot be provided as a need met in common, as specified. The bill would state that provision of the services described in the bill is presumed to be meeting a common need of all housemates.

This bill would require a county to provide notice to each recipient who receives a reduction in his or her authorized hours as a result of the implementing of a shared living arrangement reduction in hours resulting from services provided by a housemate as a need met in common, as specified in the bill. The bill would require the State Department of Social Services, in consultation with the State Department of Health Care Services, to develop a standard form for use to certify the existence of a specific need for a service that cannot be provided by a housemate as a need met in common.

This bill would authorize the State Department of Social Services to implement its provisions through all-county letters or similar instructions, pending the adoption of regulations, by July 1, 2012. The bill would become operative on the first day of the first month following 90 days after the effective date of the bill, or July 1, 2011, whichever is later.

By increasing county duties in administering the IHSS program, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

An act to amend Section 12300 of the Welfare and Institutions Code, relating to public social services, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: In-home supportive services.

Existing law provides for the county-administered In-Home Supportive Services (IHSS) program, under which qualified aged, blind, and disabled persons receive services enabling them to remain in their own homes. Existing law defines supportive services for purposes of the IHSS program. Under existing law, where supportive services are performed by a person having the legal duty to care for his or her child, who is the recipient, the provider of those services is only entitled to be remunerated for providing those services under certain circumstances.

Existing law requires the State Department of Health Care Services to seek approval of an amendment to the Medicaid state plan, to be known as the IHSS Plus option, to provide certain self-directed personal assistance services under the IHSS program as a Medi-Cal benefit, to the extent that federal financial participation is available. Under existing law, a recipient who is eligible to receive services under the

IHSS Plus option is not eligible to receive the same services under a specified Medi-Calwaiver.

This bill would delete existing requirements for providing supportive services to a recipient who is the provider's child, and instead would provide that a parent with a legal duty to provide for the care of his or her child under 18 years of age is presumed able to perform those services, including, but not limited to, domestic services and heavy cleaning, unless the parent is physically or mentally unable to provide those services, as specified. The bill would prohibit payment to the provider for these services.

This bill would authorize a nonparent provider to provide and be paid for providing, certain other services for the recipient, including, but not limited to, meal preparation and transportation, when the parent is unavailable to perform these services, as specified. This bill would authorize a parent, under certain circumstances, to be paid for performing certain services, including, but not limited to, paramedical services and protective supervision, subject to specified exceptions, and unless an able second parent is available to perform those services.

This bill would revise cross-references to refer to the IHSS Plus option. The bill would authorize the department to implement its provisions through all-county letters or similar instructions, pending the adoption, by July 1, 2012, of regulations. The changes made by the bill would become operative on the later of the first day of the first calendar month following 90 days after the effective date of the bill, or July 1, 2011.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 12300 of the Welfare and Institutions Code is amended to read:

12300. (a) The purpose of this article is to provide in every county in a manner consistent with this chapter and the annual Budget Act those supportive services identified in this section to aged, blind, or disabled persons, as defined under this chapter, who are unable to perform the services themselves and who cannot safely remain in their homes or abodes of their own choosing unless these services are provided.

(b) Supportive services shall include domestic services and services related to domestic services, heavy cleaning, personal care services, accompaniment by a provider when needed during necessary travel to health-related appointments or to alternative resource sites, yard hazard abatement, protective supervision, teaching and demonstration directed at reducing the need for other supportive services, and paramedical services which make it possible for the recipient to establish and maintain an independent living arrangement.

(c) Personal care services shall mean all of the following:

(1) Assistance with ambulation.

(2) Bathing, oral hygiene, and grooming.

(3) Dressing.

(4) Care and assistance with prosthetic devices.

(5) Bowel, bladder, and menstrual care.

(6) Repositioning, skin care, range of motion exercises, and transfers.

(7) Feeding and assurance of adequate fluid intake.

(8) Respiration.

(9) Assistance with self-administration of medications.

(d) Personal care services are available if these services are provided in the beneficiary's home and other locations as may be authorized by the director. Among the locations that may be authorized by the director under this paragraph is the recipient's place of employment if all of the following conditions are met:

(1) The personal care services are limited to those that are currently authorized for a recipient in the recipient's home and those services are to be utilized by the recipient at the recipient's place of employment to enable the recipient to obtain, retain, or return to work. Authorized services utilized by the recipient at the recipient's place of employment shall be services that are relevant and necessary in supporting and maintaining employment. However, workplace services shall not be used to supplant any reasonable accommodations required of an employer by the Americans with Disabilities Act (42 U.S.C. Sec. 12101 et seq.; ADA) or other legal entitlements or third-party obligations.

(2) The provision of personal care services at the recipient's place of employment shall be authorized only to the extent that the total hours utilized at the workplace are within the total personal care services hours authorized for the recipient in the home. Additional personal care services hours may not be authorized in connection with a recipient's employment.

~~(e) Where supportive services are provided by a person having the legal duty pursuant to the Family Code to provide for the care of his or her child who is the~~

~~recipient, the provider of supportive services shall receive remuneration for the services only when the provider leaves full-time employment or is prevented from obtaining full-time employment because no other suitable provider is available and where the inability of the provider to provide supportive services may result in inappropriate placement or inadequate care.~~

~~These providers shall be paid only for the following:~~

~~(1) Services related to domestic services.~~

~~(2) Personal care services.~~

~~(3) Accompaniment by a provider when needed during necessary travel to health-related appointments or to alternative resource sites.~~

~~(4) Protective supervision only as needed because of the functional limitations of the child.~~

~~(5) Paramedical services.~~

(e) With respect to a recipient who is under 18 years of age and living with his or her parent or parents, who have the legal duty pursuant to the Family Code to provide for the recipient's care, the parent shall be presumed able to perform the following services unless the parent provides medical verification of a physical or mental impairment that results in an inability to do so:

(1) An able parent is presumed available to perform, and except as provided in paragraph (2), there shall be no payment to any provider for performing, any of the following services:

(A) Domestic services.

(B) Services related to domestic services.

(C) Yard hazard abatement.

(D) Teaching and demonstration.

(E) Heavy cleaning.

(2) An able parent shall be presumed available to perform the following services, except during those times when he or she is unavailable for employment for health reasons. A nonparent provider may be paid for the following services only because these services must be provided because a parent is unavailable:

(A) Meal preparation.

(B) Transportation.

(C) Paramedical services.

(D) Personal care services.

(E) Protective supervision.

(3) An able parent is presumed available to perform the services listed in subparagraphs (A) to (D), inclusive. Except as provided in subdivision (f) of Section 14132.95, or as provided in this paragraph, an able parent may be paid to provide the services listed below when he or she leaves full-time employment or wishes to seek employment but is prevented from doing so because no other suitable provider is available. An able second nonprovider parent living with the recipient shall be considered a suitable provider and presumed available to provide the services listed below except during those times when he or she is not available because of employment or health. When an able second parent is available, no parent may receive payment for any of the following service:

(A) Transportation.

(B) Paramedical services.

(C) Personal care services.

(D) Protective supervision.

(f) To encourage maximum voluntary services, so as to reduce governmental costs, respite care shall also be provided. Respite care is temporary or periodic service for eligible recipients to relieve persons who are providing care without compensation.

(g) A person who is eligible to receive a service or services under an approved federal waiver authorized pursuant to Section ~~14132.951~~ 14132.952, or a person who is eligible to receive a service or services authorized pursuant to Section 14132.95, shall not be eligible to receive the same service or services pursuant to this article. In the event that the ~~waiver~~ state plan amendment authorized pursuant to Section ~~14132.951~~ 14132.952, as approved by the federal government, does not extend eligibility to all persons otherwise eligible for services under this article, or does not cover a service or particular services, or does not cover the scope of a service that a person would otherwise be eligible to receive under this article, those persons who are not eligible for services, or for a particular service under ~~the waiver or~~ Section 14132.95 or 14132.952 shall be eligible for services under this article.

(h) (1) All services provided pursuant to this article shall be equal in amount, scope, and duration to the same services provided pursuant to Section 14132.95, including any adjustments that may be made to those services pursuant to subdivision (e) of Section 14132.95.

(2) Notwithstanding any other provision of this article, the rate of reimbursement for in-home supportive services provided through any mode of service shall not exceed

the rate of reimbursement established under subdivision (j) of Section 14132.95 for the same mode of service unless otherwise provided in the annual Budget Act.

(3) The maximum number of hours available under Section 14132.95, Section ~~14132.951~~ 14132.952, and this section, combined, shall be 283 hours per month. Any recipient of services under this article shall receive no more than the applicable maximum specified in Section 12303.4.

(i) (1) Notwithstanding the rulemaking provisions of the Administrative Procedure Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement and administer the amendments made to this section by the act that added this subdivision through all-county letters or similar instructions from the department until regulations are adopted. The department shall adopt emergency regulations implementing this section no later than July 1, 2012. The department may readopt any emergency regulation authorized by this subdivision that is the same as or substantially equivalent to an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the one readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the one readoption of emergency regulations authorized by this subdivision shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State

and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(j) The amendments to this section made by the act that added this subdivision shall become operative on the first day of the first calendar month following 90 days after the effective date of the act that added this subdivision, or July 1, 2011, whichever is later.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary to implement the Budget Act of 2011, it is necessary for this act to take effect immediately.

- 0 -

An act to amend Sections 12301.03, 12301.05, and 12301.06 of the Welfare and Institutions Code, relating to public social services, and declaring the urgency thereof, to take effect immediately.

Existing law reduces the hours of service for IHSS recipients by 3.6% through the 2011–12 fiscal year, after which the recipients' authorized service hours would be restored, as specified.

This bill would reinstate the 12% reduction in IHSS hours that was imposed in the 1992–93 fiscal year, and would decrease the amount of that reduction to 8.4%, commencing on the first day of the first calendar month following 90 days after effective date of the bill, or July 1, 2011, whichever is later. The bill would revise related application procedures for an IHSS Care Supplement, and would require the IHSS Care Supplement application process to be completed before a request for a state hearing to consider the appeal of a rate reduction is submitted. The bill would provide that a recipient is eligible for aid paid pending, if an IHSS Care Supplement application is filed within a specified time period. This bill would eliminate the 2011–12 fiscal year restriction applicable to the 3.6% service hour reduction, making that reduction permanent, and resulting in a combined reduction in hours of 12%. The bill would revise applicable notice requirements and make other conforming changes.

This bill would authorize the State Department of Social Services to implement certain of its provisions by all-county letters or similar instructions pending the adoption, by January 1, 2013, of regulations.

This bill would increase county duties in administering the IHSS program, including the IHSS Care Supplement process, thereby imposing a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 12301.03 of the Welfare and Institutions Code is amended to read:

12301.03. (a) Notwithstanding any other provision of law, ~~effective October 1, 1992, and for the remainder of the 1992-93 fiscal year, unless additional funds become available earlier for IHSS from the personal care option, the department shall implement a 12~~ the department shall implement an 8.4 percent reduction in authorized hours of service to each recipient of services under this article. For those recipients who have a documented unmet need because of the limitations contained in Section 12303.4, this reduction shall be applied first to the unmet need before being applied to the hours to be authorized. If the recipient believes he or she will be at serious risk of out-of-home placement as a consequence of the reduction, the recipient may apply for a restoration of reduction pursuant to Section 12301.05.

(b) It is the intent of the Legislature to encourage counties, to the extent possible, to achieve reductions in a manner that least disrupts the continuity of services to recipients. Counties are further encouraged, to the extent possible, to assist recipients in locating supplemental services, such as congregate or home-delivered meals, ~~and to assist providers in obtaining additional hours of employment to mitigate the impact of reductions upon them~~.

(c) Notice of the reduction required by subdivision (a) shall be provided to each recipient and shall include the following information:

(1) The amount of hours the recipient received prior to the reduction and the amount of hours the recipient is to receive as a result of the reduction.

(2) The reason for the reduction.

~~(3) A statement that the reduction shall be effective through June 30, 1993, unless additional funds become available earlier for IHSS as a result of provision of Personal Care services.~~

~~(4)~~

(3) How all or part of the reduction may be restored as set forth in Section 12301.05 if the recipient believes he or she will be at serious risk of out-of-home placement as a consequence of the reduction.

~~(d) Notice of the reduction shall be provided to providers as expeditiously as possible by the Controller, in consultation with the department.~~

(d) The IHSS Care Supplement application process described in Section 12301.05 shall be completed before a request for a state hearing is submitted. If the IHSS Care Supplement application is filed within 10 days of the notice of action required by subdivision (c), or before the effective date of the reduction, the recipient shall be eligible for aid paid pending. A notice of action shall be issued by the county following evaluation of the IHSS Care Supplement application.

(e) Notwithstanding Section 11004, in any proceeding pursuant to Section 10950 where it has been determined that the sole issue was the reduction required by this section, any aid paid pending the hearing shall be recoverable as an overpayment.

(f) (1) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department may implement and administer this section through all-county letters or similar instructions from the department until regulations

are adopted. The department shall adopt emergency regulations implementing this section no later than January 1, 2013. The department may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the one readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(g) The amendments to this section by the act that added this subdivision shall become operative on the first day of the first calendar month following 90 days after the effective date of the act that added this subdivision, or July 1, 2011, whichever is later.

SEC. 2. Section 12301.05 of the Welfare and Institutions Code is amended to read:

12301.05. (a) Any aged, blind, or disabled individual who is eligible for services under this chapter ~~who has had his or her~~ whose services are reduced under subdivision (a) of Section 12301.03 but who believes he or she is at serious risk of out-of-home

placement unless all or part of the reduction is restored may ~~apply for an IHSS care supplement~~ submit an IHSS Care Supplement application. Where there is ~~such~~ an IHSS Care Supplement application within 10 days of receiving the reduction notice or prior to the implementation of the reduction, the IHSS shall continue at the unreduced level until the county finds that the recipient does or does not require restoration of any hours through the IHSS ~~care supplement~~ Care Supplement. If the recipient disagrees with the county's determination concerning the need for the IHSS ~~care supplement~~ Care Supplement, the recipient may request a hearing on that determination. ~~However, there will be no aid paid pending in that case.~~

(b) For purposes of subdivision (a), an individual is ~~in~~ at serious risk of out-of-home placement only if ~~(1) the individual meets the criteria for long-term care services as set forth in the Manual of Criteria for Medi-Cal Authorization published by the State Department of Health Services (January 1, 1982, last amended September, 1991), or (2) the individual cannot summon emergency assistance~~ the individual meets the criteria for long-term care services, as set forth in the Manual of Criteria for Medi-Cal Authorization published by the State Department of Health Care Services (January 1, 1982, last amended April 15, 2004).

(c) The county shall give a high priority to prompt screening of these persons to determine their need for IHSS Care Supplement.

(d) (1) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) the department may implement and administer this section through all-county letters or similar instructions from the department until

regulations are adopted. The department shall adopt emergency regulations implementing this section no later than January 1, 2013. The department may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the one readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(e) The amendments made to this section by the act that added this subdivision shall become operative on the first day of the first calendar month following 90 days after the effective date of the act that added this subdivision, or July 1, 2011, whichever is later.

SEC. 3. Section 12301.06 of the Welfare and Institutions Code is amended to read:

12301.06. (a) (1) Notwithstanding any other provision of law, except as provided in subdivision (d), the department shall implement a 3.6-percent reduction in authorized hours of service to each recipient of services under this article, which shall be applied

to the recipient's hours as authorized pursuant to the most recent assessment. ~~This reduction shall be effective 90 days after the enactment of the act that adds this section.~~ The reduction required by this section shall not preclude any reassessment to which a recipient would otherwise be entitled. However, hours authorized pursuant to a reassessment shall be subject to the 3.6-percent reduction required by this section.

(2) A recipient of services under this article may direct the manner in which the reduction of hours is applied to the recipient's previously authorized services.

(3) For those individuals who have a documented unmet need excluding protective supervision because of the limitations on authorized hours under Section 12303.4, the reduction shall be taken first from the documented unmet need.

~~(b) (1) The reduction in hours of service pursuant to subdivision (a) shall cease to be implemented on July 1, 2012.~~

~~(2) It is the intent of the Legislature that on July 1, 2012, services shall be restored to the level authorized pursuant to the recipient's most recent assessment, and increased by the previously deducted 3.6 percent.~~

~~(c) The~~

(b) Notice of the reduction required by subdivision (a) shall be provided to each recipient. The notice of action informing the recipient of the reduction pursuant to subdivision (a) shall be mailed at least 30 days prior to the reduction going into effect. The notice of action shall be understandable to the recipient and translated into all languages spoken by a substantial number of the public served by the In-Home Supportive Services program, in accordance with Section 7295.2 of the Government Code. The notice shall not contain any recipient financial or confidential identifying

information other than the recipient's name, address, and Case Management Information and Payroll System (CMIPS) client identification number, and shall include, but not be limited to, all of the following information:

(1) The aggregate number of authorized hours before the reduction pursuant to subdivision (a) and the aggregate number of authorized hours after the reduction.

(2) That the recipient may direct the manner in which the reduction of authorized hours is applied to the recipient's previously authorized services.

~~(3) That the reduction of hours shall remain in effect until July 1, 2012, at which time service hours shall be restored to the recipient's authorized level, based on the most recent assessment, and increased by the previously deducted 3.6 percent.~~

~~(d)~~

(c) A recipient shall have all appeal rights otherwise provided for under Chapter 7 (commencing with Section 10950) of Part 2.

~~(e)~~

(d) (1) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department may implement and administer this section through all-county letters or similar instructions from the department.

~~(f) This section shall become inoperative on July 1, 2012, and, as of January 1, 2013, this section is repealed, unless a later enacted statute that is enacted before January 1, 2013, deletes or extends the dates on which it becomes inoperative and is repealed.~~

SEC. 4. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for

those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 5. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary to implement the Budget Act of 2011, it is necessary that this act take effect immediately.

- 0 -

An act to add Section 12309.1 to the Welfare and Institutions Code, relating to public social services, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: In-Home Supportive Services program: medical certification.

Existing law provides for the In-Home Supportive Services (IHSS) program, under which qualified aged, blind, and disabled persons receive services enabling them to remain in their own homes. Under existing law, counties are responsible for administering the program.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services, under which health care services are provided to qualified low-income persons, including specified in-home services. Under existing law, IHSS recipients who are eligible for the Medi-Cal program are provided with personal care option services, as defined, in lieu of receiving these services under the IHSS program.

This bill would require, as a condition of receiving services under the IHSS program or personal care option services under the Medi-Cal program, that an applicant

for or recipient of services obtain a certification from a licensed physician or other appropriate medical professional, as determined by the department, that due to functional limitations the applicant or recipient is unable to perform the services independently and without the services is at risk of placement in out-of-home care. This bill would require the State Department of Social Services, in consultation with the State Department of Health Care Services, to develop the prescribed medical certification form. This bill would provide that its provisions become operative the first day of the first full month following 90 days after enactment or July 1, 2011, whichever is later.

Because this bill would require counties to perform additional responsibilities in administering the IHSS program, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 12309.1 is added to the Welfare and Institutions Code, to read:

12309.1. (a) As a condition of receiving services under this article, or Section 14132.95 or 14132.952, an applicant for or recipient of services shall obtain a certification from a licensed physician or other appropriate medical professional, as determined by the department, that due to functional limitations, the applicant or recipient is unable to perform the services independently and that without the services the applicant or recipient is at risk of placement in out-of-home care.

(1) Except as provided in subdivision (c), the certification must be received prior to service authorization and no services shall be authorized in the absence of the certification.

(2) The county shall consider the certification as one indicator of the need for in-home supportive services, but the certification shall not be determinative.

(3) The medical certification shall include, at a minimum, all of the following:

(A) A description of the individual's functional limitations related to the individual's need for the services.

(B) A statement that the individual is unable to perform the services independently and that unless the services are provided the individual is at risk of placement in out-of-home care.

(b) The department, in consultation with the State Department of Health Care Services, shall develop a medical certification form that includes, but is not limited to, all of the conditions in paragraph (3) of subdivision (a).

(c) This section shall not apply to a recipient who is receiving services in accordance with this article or Section 14132.95 or 14132.952 on the operative date of this section until the date of the recipient's first reassessment following the operative date of this section. The recipient shall submit the medical certification within 30 days following the reassessment in order to continue to be authorized for receipt of services.

(d) After submission of a medical certification pursuant to subdivision (a) or (c), the county shall determine whether it needs to obtain a more current certification from a licensed physician or other appropriate medical professional, as determined by the department, when the county reassesses a recipient's need for services pursuant to Section 12301.1. The county may require that a beneficiary provide a more current medical certification if the county determines that it is necessary. The county shall document the basis for its determination that a more current medical certification is required in the recipient's case file.

(e) This section shall become operative the first day of the first full month following 90 days after the enactment of the act that adds this section, or July 1, 2011, whichever is later.

(f) (1) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department may implement and administer this section through all-county letters or similar instruction from the department until such time as regulations are adopted. The department shall adopt emergency regulations implementing this section no later than July 1, 2012. The department may readopt any emergency regulation previously adopted in accordance with this section that is the

same as or substantially equivalent to an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the one readoption of emergency regulations authorized by this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

SEC. 2. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 3. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary for implementation of the Budget Act of 2011, it is necessary that this act take effect immediately.

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Proposed Trailer Bill Language

Issue 639—Make IHSS Advisory Committees Optional

SECTION 1. It is the intent of the Legislature to enact legislation to make the establishment of In-Home Supportive Services Advisory Committees optional for counties.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary for implementation of the Budget Act of 2011, it is necessary that this act take effect immediately.

05188

An act to add Section 4648.8 to the Welfare and Institutions Code, relating to developmental services, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Regional center purchase of services standards.

Existing law, the Lanterman Developmental Disabilities Services Act, requires the State Department of Developmental Services to enter into contracts with private nonprofit regional centers for the provision of community services and support for persons with developmental disabilities and their families, including, but not limited to, residential placement. Existing law sets forth the duties of the regional centers, including, but not limited to, development of individual program plans, the purchase of needed services to implement the plan, and the monitoring of services.

This bill would require the department to develop purchase of services standards for use by regional centers when purchasing services for consumers and families. The bill would require the department to submit the standards, and draft statutory language necessary to implement required changes, to the Legislature by an unspecified date.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 4648.8 is added to the Welfare and Institutions Code, to read:

4648.8. Notwithstanding any other provision of law to the contrary:

(a) To provide more uniformity and consistency in the services, funding, and administrative practices of regional centers throughout the state while ensuring consistency with Lanterman Act values and maintaining the entitlement to services, and to increase cost effectiveness, the Department of Developmental Services (department), with input from stakeholders, shall develop standards for regional centers to use when purchasing services for consumers and families. In developing these standards, the department shall consider eligibility for the service; duration; frequency and efficacy of the service; service providers qualifications and performance; rates; parental and consumer responsibilities and self directed service options. The department shall ensure that changes are made through the Individual Program Planning process outlined in the Lanterman Act and specify the notification requirements. The department shall also consider the impact of the standards, coupled with prior reductions in the service area, on consumers, families, and providers. The department shall submit the standards to the Legislature by _____ with draft statutory language necessary to implement required changes. The department shall include specific cost savings estimates associated with the standards.

(b) Standards developed pursuant to this section may vary by service category and:

(1) Establish criteria and limits on the type, scope, amount, duration, location, and intensity of services and supports purchased by regional centers for consumers and their families.

(2) Prohibit the purchase of specified services.

(3) Change payment rates.

(4) Impact family and consumer responsibilities.

(c) In developing these standards, the department shall consider provisions for limited individual exceptions to ensure the health and safety of the consumer or to avoid out-of-home placement or institutionalization.

(d) Standards developed pursuant to this section shall not:

(1) Endanger a consumer's health or safety.

(2) Compromise the state's ability to meet its commitments to the federal Centers for Medicare and Medicaid Services for participation in the Home and Community-based Services waiver or other federal funding of services for persons with developmental disabilities.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary for implementation of the Budget Act of 2011, it is necessary that this act take effect immediately.

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An act to add Article 2.6 (commencing with Section 4659.10) to Chapter 5 of Division 4.5 of the Welfare and Institutions Code, relating to developmental services, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Regional centers: dispute resolution: third-party liability.

Under existing law, the Lanterman Developmental Disabilities Services Act, the State Department of Developmental Services is authorized to contract with regional centers to provide support and services to individuals with developmental disabilities. Under existing law, the regional centers purchase needed services for individuals with developmental disabilities through approved service providers or arrange for their provision through other publicly funded agencies. Existing law establishes procedures for the resolution of disputes between a regional center and a generic agency, as defined, over provision of, or payment for, services that are contained in an individualized family service plan or individual program plan for any child under 6 years of age.

Existing law, the California Early Intervention Services Act, provides various early intervention services for infants and toddlers who have disabilities to enhance their development and to minimize the potential for developmental delays.

This bill would establish procedures authorizing the department or regional center to institute legal proceedings against a 3rd party or insurance carrier, as specified, when developmental services are provided or will be provided to a developmental services consumer, or a child under 36 months of age who is eligible for the California Early Intervention Program, as a result of an injury for which the 3rd party or carrier is liable.

This bill would entitle the department or regional center to recover the reasonable value of services provided to the child or consumer from a person who has brought an action or claim against a 3rd party who may be liable for causing the death of the child or consumer. The bill would provide for a similar recovery provision when the action is brought by the child or consumer, but would provide for the deduction of a share of the child's or consumer's attorney's fees and litigation costs from the reasonable value of the services provided, as specified. The bill would set forth the powers and duties of the department in recouping these amounts, and would prohibit the department or regional center from recovering an amount greater than the child or consumer.

This bill would establish procedures for the enforcement of a lien perfected by the department or regional center upon a judgment or award in favor of a child or consumer for a 3rd-party injury. This bill would require an insurer, as defined, to perform various duties relating to actions or claims brought pursuant to the bill, including a requirement to make requested information available to the department or regional center, pursuant to procedures set forth in a cooperative agreement entered into by the insurer and the department or regional center.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Article 2.6 (commencing with Section 4659.10) is added to Chapter 5 of Division 4.5 of the Welfare and Institutions Code, to read:

Article 2.6. Third-Party Liability

4659.10. It is the intent of the Legislature that this article shall be implemented consistent with the responsibilities of the department and the regional centers to provide services and supports pursuant to the requirements of this division and the California Early Intervention Program. It is further the intent of the Legislature that the department and the regional centers shall continue to be the payers of last resort consistent with the requirements of this division and the California Early Intervention Program.

4659.11. (a) When services are provided or will be provided to a consumer under this division, or to a child under 36 months of age who is eligible for the California Early Intervention Program pursuant to Title 14 of the Government Code (commencing with Section 95000), as a result of an injury for which another person is liable, or for which an insurance carrier is liable in accordance with the provisions of any policy of insurance issued pursuant to Section 11580.2 of the Insurance Code, the department or the regional center from which the individual obtained services shall have a right to recover from the person or carrier the reasonable value of services so provided. To enforce that right, the department or the regional center may institute and prosecute legal proceedings against the third person or carrier who may be liable for the injury in an appropriate court, either in the name of the department or regional

center or in the name of the child or consumer, his or her guardian, conservator, limited conservator, personal representative, estate, or survivors.

(b) The department and the regional center may compromise, or settle and release a claim as described in subdivision (a).

(c) The department may waive a claim as described in subdivision (a), in whole or in part, if the department determines that collection would not be cost-efficient, would result in undue hardship upon the consumer or child who suffered the injury, or in a wrongful death action upon the heirs of the deceased.

(d) No action taken on behalf of the department or the regional center pursuant to this section or any judgment rendered in that action shall be a bar to any action upon the claim or cause of action of the child or consumer, his or her guardian, conservator, personal representative, estate, dependents, or survivors against the third party who may be liable for the injury, or shall operate to deny to the child or consumer the recovery for that portion of any damages not covered hereunder.

(e) The department and the State Department of Health Care Services shall work together to ensure that the recovery sought by the department, regional centers, and the State Department of Health Care Services for services for Medi-Cal beneficiaries with developmental disabilities is appropriate.

4659.12. (a) Where an action is brought by the department or a regional center pursuant to Section 4659.11, it shall be commenced within the period prescribed in Section 338 of the Code of Civil Procedure.

(b) The death of a consumer or child under 36 months of age who is eligible for the California Early Intervention Program does not abate any right of action established by Section 4659.11.

(c) When an action or claim is brought by a person or persons entitled to bring the action or assert the claim against a third party who may be liable for causing the death of the child or consumer, any settlement, judgment, or award obtained is subject to the right of the department or the regional center to recover from that party the reasonable value of the services provided to the consumer under this division.

(d) Where the action or claim is brought by the child or consumer alone, and the child or consumer incurs a personal liability to pay attorney's fees and costs of litigation, the claim for reimbursement by the department or the regional center of the services provided to the child or consumer shall be limited to the reasonable value of services less 25 percent, which represents the department's or the regional center's reasonable share of attorney's fees paid by the child or consumer, and that portion of the cost of litigation expenses determined by multiplying by the ratio of the full amount of the reasonable value of services so provided to the full amount of the judgment, award, or settlement.

4659.13. (a) If a consumer or child under 36 months of age who is eligible for the California Early Intervention Program, the department, or a regional center brings an action or claim against a third party or carrier, the consumer, child, regional center, or department, within 30 days of filing the action, shall provide the other persons or entities specified in this subdivision with written notice by personal service or registered mail of the action or claim, and of the name of the court or state or local agency in

which the action or claim is brought. Proof of the notice shall be filed in the action or claim. If an action or claim is brought by the department, the regional center, the child, or the consumer, any of the other persons or entities described in this subdivision, at any time before trial on the facts, may become a party to, or shall consolidate, their action or claim with, another action or claim if brought independently.

(b) If an action or claim is brought by the department or the regional center pursuant to subdivision (a) of Section 4659.11, written notice to the child, consumer, guardian, conservator, personal representative, estate, or survivor given pursuant to this section shall advise him or her of his or her right to intervene in the proceeding, his or her right to obtain a private attorney of his or her choice, and the department's right to recover the reasonable value of the services provided.

4659.14. In the event of judgment or award in a suit or claim against a third party or carrier:

(a) If the action or claim is prosecuted by the child or consumer alone, the court or agency shall first order paid from any judgment or award the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney's fees, when an attorney has been retained. After payment of these expenses and attorney's fees the court or agency, on the application of the department or the regional center, shall allow as a lien against the amount of the settlement, judgment, or award, the reasonable value of additional services provided to the child under the California Early Intervention Program or consumer under this division, as provided in subdivision (d) of Section 4659.12.

(b) If the action or claim is prosecuted both by the consumer or child and the department or regional center, the court or agency shall first order paid from any judgment or award the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney's fees based solely on the services rendered for the benefit of the child or consumer. After payment of these expenses and attorney's fees, the court or agency shall apply out of the balance of the judgment or award an amount sufficient to reimburse the department the full amount of the reasonable value of services provided.

4659.15. Upon further application at any time before the judgment or award is satisfied, the court shall allow as a further lien the reasonable value of additional services provided arising out of the same cause of action or claim provided on behalf of the consumer under this division, or child under the California Early Intervention Program, where the services were provided or became payable subsequent to the original order.

4659.16. (a) No settlement, judgment, or award in any action or claim by a consumer or child to recover damages for injuries, where the department or regional center has an interest, shall be deemed final or satisfied without first giving the department notice and a reasonable opportunity to perfect and to satisfy the department's or regional center's lien. Recovery of the lien from an injured consumer's or child's action or claim is limited to that portion of a settlement, judgment, or award that represents payment for services provided on behalf of the consumer under this division or a child under the California Early Intervention Program. All reasonable efforts shall be made to obtain the department's advance agreement to a determination as to what

portion of a settlement, judgment, or award represents payment for services provided on behalf on the consumer under this division or the child under the California Early Intervention Program. Absent the department's advance agreement as to what portion of a settlement, judgment, or award represents payment for medical expenses, or medical care, provided to the child or consumer, the matter shall be submitted to a court for decision. The department, the regional center, or the child or consumer may seek resolution of the dispute by filing a motion, which shall be subject to regular law and motion procedures.

(b) If the child or consumer has filed a third-party action or claim, the court in which the action or claim was filed shall have jurisdiction over a dispute between the department or regional center and the child or consumer regarding the amount of a lien asserted pursuant to this section that is based upon an allocation of damages contained in a settlement or compromise of the third-party action or claim. If no third-party action or claim has been filed, any superior court in California where venue would have been proper, had a claim or action been filed, shall have jurisdiction over the motion. The motion may be filed as a special motion and treated as an ordinary law and motion proceeding subject to regular motion fees. The reimbursement determination motion shall be treated as a special proceeding of a civil nature pursuant to Part 3 (commencing with Section 1063) of the Code of Civil Procedure. When no action is pending, the person making the motion shall be required to pay a first appearance fee. When an action is pending, the person making the motion shall pay a regular law and motion fee. Notwithstanding Section 1064 of the Code of Civil Procedure, the child or

consumer, the regional center, or the department may appeal the final findings, decision, or order.

(c) The court shall issue its findings, decision, or order, which shall be considered the final determination of the parties' rights and obligations with respect to the department's lien, unless the settlement is contingent on an acceptable allocation of the settlement proceeds, in which case, the court's findings, decision, or order shall be considered a tentative determination. If the child or consumer does not serve notice of a rejection of the tentative determination, which shall be based solely upon a rejection of the contingent settlement, within 30 days of the notice of entry of the court's tentative determination, subject to further consideration by the court pursuant to subdivision (d), the tentative determination shall become final. Notwithstanding Section 1064 of the Code of Civil Procedure, the child, consumer, regional center, or department may appeal the final findings, decision, or order.

(d) If the consumer or child does not accept the tentative determination, which shall be based solely upon a rejection of the contingent settlement, any party may subsequently seek further consideration of the court's findings upon application to modify the prior findings, decision, or order based on new or different facts or circumstances. The application shall include an affidavit showing what application was made before, when, and to what judge, what order or decision was made, and what new or different facts or circumstances, including a different settlement, are claimed to exist. Upon further consideration, the court may modify the allocation in the interest of fairness and for good cause.

4659.17. When the department or regional center has perfected a lien upon a judgment or award in favor of a child eligible for the California Early Intervention Program or a consumer against any third party for an injury for which the consumer has received services pursuant to this division, the department or the regional center shall be entitled to a writ of execution as lien claimant to enforce payment of the lien against the third party with interest and other accruing costs as in the case of other executions. In the event the amount of the judgment or award so recovered has been paid to the child or consumer, the department or the regional center shall be entitled to a writ of execution against the child or consumer to the extent of the department's or the regional center's lien, with interest and other accruing costs as in the case of other executions.

4659.18. Notwithstanding any other provision of law, in no event shall the department or the regional center recover an amount greater than the child eligible for the California Early Intervention Program or consumer recovers after deducting from the settlement judgment, or award, attorney's fees and litigation costs paid for by the child or consumer. If the recovery of the department or regional center is determined under this section, the reductions in subdivision (d) of Section 4659.12 shall not apply.

4659.19. The amount recovered by the department or regional center shall not exceed the amount derived from applying Section 4659.12, 4659.16, or 4659.18, whichever is less.

4659.20. In the event that the child or consumer, his or her guardian, conservator, limited conservator, personal representative, estate, or survivors, or any of them brings an action against the third party that may be liable for the injury, notice of institution

of legal proceedings, notice of settlement, and all other notices required by this article shall be given to the director of the department in Sacramento except in cases where the director specifies that notice shall be given to the Attorney General. All notices shall be given by insurance carriers, as described in Section 14124.70, having liability for the child's or consumer's claim, and by the attorney retained to assert the claim by the consumer or child, or by the injured child or consumer, his or her guardian, conservator, limited conservator, personal representative, estate, or survivors, if no attorney is retained.

4659.21. Notwithstanding any other provision of law, all carriers described in Section 14124.70, including automobile, casualty, property, and malpractice insurers, shall enter into agreements with regional centers and the department to permit and assist the matching of the eligibility files of the department and the regional centers against the carrier's claim files, utilizing, if necessary, social security numbers as common identifiers for the purpose of determining whether services were provided to a child eligible for the California Early Intervention Program or consumer because of an injury for which another person is liable, or for which a carrier is liable in accordance with the provisions of any policy of insurance. The carrier shall maintain a centralized file of claimants' names, mailing addresses, and social security numbers or dates of birth. This information shall be made available to the department and the regional center upon a reasonable request by the department or a regional center. The agreement described in this section shall include financial arrangements for reimbursing carriers for necessary costs incurred in furnishing requested information.

4659.22. (a) Every health insurer, self-insured plan, group health plan, as defined in Section 607(1) of the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1001, et seq.), service benefit plan, managed care organization, including health care service plans as defined in subdivision (f) of Section 1345 of the Health and Safety Code, licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, upon request of the department or a regional center for any records, or any information contained in records pertaining to, an individual or group health insurance policy or plan issued by the insurer or plan against, or pertaining to, the services paid by or claims made against the insurer or plans under a policy or plan, shall make the requested records or information available upon a certification by the department or regional center that the individual is an applicant for or recipient of services under this division, is an applicant for or recipient of services under the California Early Intervention Program, or is a person who is legally responsible for the applicant or recipient.

(b) The department or regional center shall enter into a cooperative agreement setting forth mutually agreeable procedures for requesting and furnishing appropriate information, consistent with laws pertaining to the confidentiality and privacy of medical records. These procedures shall include any financial arrangements as may be necessary to reimburse insurers or plans for necessary costs incurred in furnishing requested information, and the time and manner those procedures are to become effective.

(c) The information required to be made available pursuant to this section shall be limited to information necessary to determine whether services have been or should have been claimed and paid pursuant to a health insurance policy or plan with respect to services received by a particular individual for which services under this division or under the California Early Intervention Program would be available.

(d) Not later than the date upon which the procedures agreed to pursuant to subdivision (b) become effective, the director shall establish guidelines to ensure that information relating to an individual certified to be an applicant child or consumer, furnished to any insurer or plan pursuant to this section, is used only for the purpose of identifying the records or information requested in the manner so as not to violate the confidentiality of an applicant or recipient.

(e) The department shall implement this section no later than _____.

4659.23. In order to assess overlapping or duplicate health coverage, every health insurer, self-insured plan, group health plan, as defined in Section 607(1) of the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1001, et seq.), service benefit plan, managed care organization, including health care service plans as defined in subdivision (f) of Section 1345 of the Health and Safety Code, licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service shall maintain a centralized file of the subscribers', policyholders', or enrollees' names, mailing addresses, and social security numbers or date of birth, and where available, for all

other covered persons, the names and social security numbers or dates of births. This information shall be made available to the department or a regional center upon reasonable request. Notwithstanding Section 20230 of the Government Code, the Board of Administration of the California Public Employees' Retirement System and affiliated systems or contract agencies shall permit data matches with the state department to identify consumers with third-party health coverage or insurance.

4659.24. (a) When the rights of a consumer or a child receiving services under the California Early Intervention Program to recovery from an insurer have been assigned to the department or a regional center, an insurer shall not impose any requirement on the department or the regional center that is different from any requirement applicable to an agent or assignee of the covered consumer or child.

(b) The department may garnish the wages, salary, or other employment income of, and withhold amounts from state tax refunds from, any person to whom both of the following apply:

(1) The person is required by a court or administrative order to provide coverage of the costs of services provided to a child under the California Early Intervention Program or a consumer under this division.

(2) The person has received payment from a third party for the costs of the services for the child or consumer, but he or she has not used the payments to reimburse, as appropriate, either the other parent or the person having custody of the child or consumer, or the provider of the services, to the extent necessary to reimburse the department for expenditures for those costs under this division. All claims for current

or past due child support shall take priority over claims made by the department or the regional center.

(c) For purposes of this section, "insurer" includes every health insurer, self-insured plan, group health plan, as defined in Section 607(1) of the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1001, et seq.), service benefit plan, managed care organization, including health care service plans as defined in subdivision (f) of Section 1345 of the Health and Safety Code, licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make necessary changes to implement the Budget Act of 2011, it is necessary for this act to take effect immediately.

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An act to amend Section 4474.5 of the Welfare and Institutions Code, relating to developmental services, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Closure of developmental centers: consumer transition.

Existing law establishes the State Department of Developmental Services and sets forth its powers and duties, including, but not limited to, the administration and oversight of developmental centers and programs to provide services and support to persons with developmental disabilities and their families.

Existing law requires the establishment of protocols to ensure appropriate services are provided for persons transitioning as a result of the planned closure of the Agnews Developmental Center and the Lanterman Developmental Center. For persons transitioning under a plan for the closure of these developmental centers who have service needs for coordinated medical and specialty care identified in their individual program plans that cannot be met using the traditional Medi-Cal fee-for-service system, existing law establishes a structure requiring provision of those services under Medi-Cal managed care health plans that are currently operational in prescribed counties as a

county organized health system or a local initiative, if consumers choose to enroll, and authorizes prescribed supplemental payments, including payments for administrative services.

This bill would recast those provisions to require, for consumers transitioning from the Lanterman Developmental Center, that the Medi-Cal managed care health plan be any plan operating in the various counties if the consumers choose to enroll, or as mandated by prescribed statutory provisions; to delete consultation with the Lanterman Developmental Center staff as an administrative service eligible for supplemental reimbursement; and to require that plans be paid a full-risk capitation payment.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 4474.5 of the Welfare and Institutions Code is amended to read:

4474.5. (a) In order to meet the unique medical health needs of consumers transitioning from Agnews Developmental Center into Alameda, San Mateo, and Santa Clara Counties pursuant to the Plan for the Closure of Agnews Developmental Center, and consumers transitioning from Lanterman Developmental Center into various health plans in central and southern California counties pursuant to the Plan for the Closure of Lanterman Developmental Center, whose individual program plans document the need for coordinated medical and specialty care that cannot be met using the traditional Medi-Cal fee-for-service system, services provided under the contract shall be provided by Medi-Cal managed care health plans that are currently operational in these counties as. For consumers transitioning from Agnews Developmental Center, the Medi-Cal managed care health plan shall be a county organized health system or a local initiative if consumers, where applicable, choose to enroll. For consumers transitioning from Lanterman Developmental Center, the Medi-Cal managed care health plan shall be any plan operating in the various counties if consumers choose to enroll or, where applicable, are enrolled by mandate pursuant to Section 14182. Reimbursement shall be by the State Department of Health Care Services for all Medi-Cal services provided under the contract that are not reimbursed by the Medicare Program.

(b) (1) Medi-Cal managed care health plans enrolling ~~members~~ consumers transitioning from Agnews Developmental Center as referred to in subdivision (a) shall

be further reimbursed for the reasonable cost of administrative services. ~~Administrative services~~

(2) Notwithstanding subdivision (c), Medi-Cal managed care health plans enrolling consumers transitioning from Lanterman Developmental Center as referred to in subdivision (a) shall be paid a full-risk capitation payment.

(3) "Administrative services" pursuant to this subdivision include, but are not limited to, coordination of care and case management not provided by a regional center, provider credentialing and contracting, quality oversight, assuring member access to covered services, consultation with Agnews Developmental Center staff, ~~Lanterman Developmental Center staff,~~ regional center staff, Department of Developmental Services staff, contractors, and family members, and financial management of the program, including claims processing. ~~Reasonable cost is defined as~~ "Reasonable cost" means the actual cost incurred by the Medi-Cal managed care health plan, including both direct and indirect costs incurred by the Medi-Cal managed care health plan, in the performance of administrative services, but shall not include any incurred costs found by the State Department of Health Care Services to be unnecessary for the efficient delivery of necessary health services. Payment for administrative services shall continue on a reasonable cost basis until sufficient cost experience exists to allow these costs to be part of an all-inclusive capitation rate covering both administrative services and direct patient care services.

(c) Until the State Department of Health Care Services is able to determine by actuarial methods, prospective per capita rates of payment for services for those members who enroll in the Medi-Cal managed care health plans specified in subdivision

(a), the State Department of Health Care Services shall reimburse the Medi-Cal managed care health plans for the net reasonable cost of direct patient care services and supplies set forth in the scope of services in the contract between the Medi-Cal managed care health plans and the State Department of Health Care Services and that are not reimbursed by the Medicare Program. ~~Net reasonable cost is defined~~ "Net reasonable cost" means the actual cost incurred by the Medi-Cal managed care health plans, as measured by the Medi-Cal managed care health plan's payments to providers of services and supplies, less payments made to the plans by third parties other than Medicare, and shall not include any incurred cost found to be unnecessary by the State Department of Health Care Services in the efficient delivery of necessary health services. Reimbursement shall be accomplished by the State Department of Health Care Services making estimated payments at reasonable intervals, with these estimates being reconciled to actual net reasonable cost at least semiannually.

(d) The State Department of Health Care Services shall seek any approval necessary for implementation of this section from the federal government, for purposes of federal financial participation under Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq.). Notwithstanding any other provision of law, ~~this section~~ subdivisions (a) to (c), inclusive, shall be implemented only to the extent that federal financial participation is available pursuant to necessary federal approvals.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary for implementation of the Budget Act of 2011, it is necessary that this act take effect immediately.

- 0 -

An act to add Sections 4622.5, 4625.5, 4629.5, 4648.12, and 4648.14 to the Welfare and Institutions Code, relating to developmental services, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Regional centers: conflicts of interest: transparency.

Existing law, the Lanterman Developmental Disabilities Services Act, requires the State Department of Developmental Services to enter into contracts with private nonprofit corporations to operate regional centers for the provision of community services and support for persons with developmental disabilities and their families, including, but not limited to, residential placement. Existing law sets forth the duties of the regional centers, including, but not limited to, development of individual program plans, the purchase of needed services to implement the plan, and monitoring of the delivery of those services.

Existing law establishes minimum requirements relating to the composition of the governing board of a regional center.

This bill would require the regional center to annually submit to the department documentation demonstrating that the composition of the board is in compliance with those statutory provisions.

This bill would require a regional center governing board to adopt a written policy requiring any regional center contract of $350,000 or more to be approved by the regional center governing board, and would condition the validity of those contracts upon board approval in compliance with that policy.

Existing law requires the 5-year contracts between the department and the regional center to contain prescribed provisions, including, but not limited to, the requirement that the contracts include annual performance objectives.

This bill would, in addition, require that the contracts include provisions requiring the regional center to adopt, maintain, and post on its Internet Web site a transparency and public information policy containing prescribed components.

The bill would require the department to establish a transparency portal on its Internet Web site to include, but not be limited to, a link to the regional center transparency and public information policy Internet Web sites, and other service monitoring and enforcement information.

This bill would make certain persons or entities that have been convicted of prescribed crimes or have been found liable for fraud or abuse in any civil proceeding, or that have entered into a settlement in lieu of conviction for fraud or abuse in any government program, within the previous 10 years, ineligible to be regional center vendors, and would require the department to adopt related emergency and nonemergency regulations. The bill would require the State Department of Social

Services and the State Department of Public Health to notify the department of any administrative action, as defined, initiated against a licensee serving consumers with developmental disabilities.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 4622.5 is added to the Welfare and Institutions Code, to read:

4622.5. By August 15 of each year, the governing board of each regional center shall submit to the department detailed documentation, as determined by the department, demonstrating that the composition of the board is in compliance with Section 4622.

SEC. 2. Section 4625.5 is added to the Welfare and Institutions Code, to read:

4625.5. (a) The governing board of each regional center shall adopt and maintain a written policy requiring the board to review and approve any regional center contract of three hundred fifty thousand dollars ($350,000) or more, before entering into the contract.

(b) No regional center contract of three hundred fifty thousand dollars ($350,000) or more shall be valid unless approved by the governing board of the regional center in compliance with its written policy pursuant to subdivision (a).

SEC. 3. Section 4629.5 is added to the Welfare and Institutions Code, to read:

4629.5. (a) In addition to the requirements set forth in Section 4629, the department's contract with a regional center shall require the regional center to adopt, maintain, and post on its Internet Web site a board-approved policy regarding transparency and access to public information. The transparency and public information policy shall provide for timely public access to information including, but not limited to, information regarding requests for proposals and contract awards, service provider rates, documentation related to establishment of negotiated rates, audits, and IRS Form 990. The transparency and public information policy shall be in compliance with

applicable law relating to the confidentiality of consumer service information and records, including, but not limited to, Section 4514.

(b) To promote transparency, each regional center shall include on its Internet Web site at least all of the following:

(1) Regional center annual independent audits.

(2) Biannual fiscal audits conducted by the department.

(3) Regional center annual reports pursuant to Section 4639.5.

(4) Contract awards, including the organization or entity awarded the contract, and the amount and purpose of the award.

(5) Purchase of service policies.

(6) The names, types of service, and contact information of all vendors, except consumers or family members of consumers.

(7) Board meeting agendas and approved minutes of open meetings of the board and all committees of the board.

(8) Bylaws of the regional center governing board.

(9) The annual performance contract and year-end performance contract entered into with the department pursuant to this division.

(10) The biannual Home and Community-based Services Waiver program review conducted by the department and the State Department of Health Care Services.

(11) The board-approved transparency and public information policy.

(12) The board-approved conflict-of-interest policy.

(c) The department shall establish and maintain a transparency portal on its Internet Web site that allows consumers, families, advocates, and others to access

provider and regional center information. Posted information on the department's Internet Web site transparency portal shall include, but need not be limited to, all of the following:

(1) A link to each regional center's Internet Web site information referenced in subdivision (b).

(2) Biannual fiscal audits conducted by the department.

(3) Vendor audits.

(4) Biannual Home and Community-based Services Waiver program reviews conducted by the department and the State Department of Health Care Services.

(5) Biannual targeted case management program and federal nursing home reform program reviews conducted by the department.

(6) Early Start Program reviews conducted by the department.

(7) Annual performance contract and year-end performance contract reports.

SEC. 4. Section 4648.12 is added to the Welfare and Institutions Code, immediately following Section 4648.1, to read:

4648.12. (a) The Legislature finds and declares that under federal and state law, certain individuals and entities are ineligible to provide Medicaid services.

(b) An individual, partnership, group association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents thereof, that has been convicted of any felony or misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of an elder or dependent adult or child, or that has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government

program, within the previous 10 years, shall be ineligible to be a regional center vendor. The regional center shall not deny vendorization to an otherwise qualified applicant whose felony or misdemeanor charges did not result in a conviction solely on the basis of the prior charges.

(c) In order to ensure compliance with federal disclosure requirements and to preserve federal funding of consumer services, the department shall do all of the following:

(1) (A) Adopt emergency regulations to amend provider and vendor eligibility and disclosure criteria to meet federal participation requirements. These emergency regulations shall address, at a minimum, disclosure requirements of current and prospective vendors, including information about entity ownership and control, contracting interests, and criminal convictions or civil proceedings involving fraud or abuse in any government program, or abuse or neglect of an elder, dependent adult, or child.

(B) Adopt emergency regulations to meet federal requirements applicable to vouchered services.

(C) The adoption, amendment, repeal, or readoption of a regulation authorized by this paragraph is deemed to be necessary for the immediate preservation of the public peace, health and safety, or general welfare, for purposes of Sections 11346.1 and 11349.9 of the Government Code, and the department is hereby exempted from that requirement. For purposes of subdivision (e) of Section 11346.1 of the Government Code, the 120-day period, as applicable to the effective period of an emergency

regulatory action and submission of specified materials to the Office of Administrative Law, is hereby extended to 180 days.

(2) Adopt nonemergency regulations to implement the terms of paragraph (1) though the regular rulemaking process pursuant to Sections 11346 and 11349.1 of the Government Code within 18 months of the adoption of emergency regulations pursuant to paragraph (1).

SEC. 5. Section 4648.14 is added to the Welfare and Institutions Code, immediately preceding Section 4648.2, to read:

4648.14. Notwithstanding any other provision of law, the State Department of Social Services and the State Department of Public Health shall notify the State Department of Developmental Services of any administrative action initiated against a licensee serving consumers with developmental disabilities. For the purposes of this section "administrative action" includes, but is not limited to, all of the following:

(a) The issuance of a citation requiring corrective action for a health and safety violation.

(b) The suspension or revocation of a license.

(c) The issuance of a temporary restraining order.

(d) The appointment of a temporary receiver pursuant to Section 1327 of the Health and Safety Code.

SEC. 6. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary for implementation of the Budget Act of 2011, it is necessary that this act take effect immediately.

- 0 -

An act to amend Section 14132 of the Welfare and Institutions Code, relating to Medi-Cal, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Medi-Cal: enteral nutrition products.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law provides that enteral formulae is a covered benefit under the Medi-Cal program, subject to the Medi-Cal list of enteral formulae and utilization controls.

This bill would, in relation to this benefit, instead refer to enteral nutrition products. This bill would require that the purchase of enteral nutrition products for persons 21 years of age and older be limited to those products administered through a gastric, nasogastric, or jejunostomy tube. This bill would authorize the department to deem specified enteral nutrition products a benefit under the Medi-Cal program that are not administered through a gastric, nasogastric, or jejunostomy tube under specified

circumstances. This bill would require its provisions to be implemented 60 days after the mailing of the beneficiary notification letter and no sooner than June 1, 2011.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14132 of the Welfare and Institutions Code is amended to read:

14132. The following is the schedule of benefits under this chapter:

(a) Outpatient services are covered as follows:

Physician, hospital or clinic outpatient, surgical center, respiratory care, optometric, chiropractic, psychology, podiatric, occupational therapy, physical therapy, speech therapy, audiology, acupuncture to the extent federal matching funds are provided for acupuncture, and services of persons rendering treatment by prayer or healing by spiritual means in the practice of any church or religious denomination insofar as these can be encompassed by federal participation under an approved plan, subject to utilization controls.

(b) Inpatient hospital services, including, but not limited to, physician and podiatric services, physical therapy and occupational therapy, are covered subject to utilization controls.

(c) Nursing facility services, subacute care services, and services provided by any category of intermediate care facility for the developmentally disabled, including podiatry, physician, nurse practitioner services, and prescribed drugs, as described in subdivision (d), are covered subject to utilization controls. Respiratory care, physical therapy, occupational therapy, speech therapy, and audiology services for patients in nursing facilities and any category of intermediate care facility for the developmentally disabled are covered subject to utilization controls.

(d) (1) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.

(2) Purchase of drugs used to treat erectile dysfunction or any off-label uses of those drugs are covered only to the extent that federal financial participation is available.

(3) (A) To the extent required by federal law, the purchase of outpatient prescribed drugs, for which the prescription is executed by a prescriber in written, nonelectronic form on or after April 1, 2008, is covered only when executed on a tamper resistant prescription form. The implementation of this paragraph shall conform to the guidance issued by the federal Centers of Medicare and Medicaid Services but shall not conflict with state statutes on the characteristics of tamper resistant prescriptions for controlled substances, including Section 11162.1 of the Health and Safety Code. The department shall provide providers and beneficiaries with as much flexibility in implementing these rules as allowed by the federal government. The department shall notify and consult with appropriate stakeholders in implementing, interpreting, or making specific this paragraph.

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instructions without taking regulatory action.

(4) (A) Nonlegend acetaminophen-containing products, with the exception of children's Tylenol, selected by the department are not covered benefits. For the purposes of this paragraph, nonlegend has the same meaning as defined in subdivision (a) of Section 14105.45.

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instruction without taking regulatory action.

(e) Outpatient dialysis services and home hemodialysis services, including physician services, medical supplies, drugs and equipment required for dialysis, are covered, subject to utilization controls.

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetist services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and X-ray services are covered, subject to utilization controls. Nothing in this subdivision shall be construed to require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable X-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses which are lost or destroyed due to circumstances beyond the beneficiary's control. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for

obtaining employment or for medical conditions that preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children Services Program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.

(3) Paragraph (2) shall become inoperative July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.

(j) Home health care services are covered, subject to utilization controls.

(k) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced

pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated, is covered subject to utilization controls. When there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

Therapeutic shoes and inserts are covered when provided to beneficiaries with a diagnosis of diabetes, subject to utilization controls, to the extent that federal financial participation is available.

(*l*) Hearing aids are covered, subject to utilization controls. Utilization controls shall allow replacement of hearing aids necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control. The utilization controls shall allow authorization of durable medical equipment needed to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian, subject to the availability of federal financial participation. The department shall adopt emergency regulations to define and establish criteria for

assistive durable medical equipment in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(n) Family planning services are covered, subject to utilization controls.

(o) Inpatient intensive rehabilitation hospital services, including respiratory rehabilitation services, in a general acute care hospital are covered, subject to utilization controls, when either of the following criteria are met:

(1) A patient with a permanent disability or severe impairment requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to develop function beyond the limited amount that would occur in the normal course of recovery.

(2) A patient with a chronic or progressive disease requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to maintain the patient's present functional level as long as possible.

(p) (1) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).

(2) Commencing 30 days after the effective date of the act that added this paragraph, and notwithstanding the number of days previously approved through a treatment authorization request, adult day health care is covered for a maximum of three days per week.

(3) As provided in accordance with paragraph (4), adult day health care is covered for a maximum of five days per week.

(4) As of the date that the director makes the declaration described in subdivision (g) of Section 14525.1, paragraph (2) shall become inoperative and paragraph (3) shall become operative.

(q) (1) Application of fluoride, or other appropriate fluoride treatment as defined by the department, other prophylaxis treatment for children 17 years of age and under, are covered.

(2) All dental hygiene services provided by a registered dental hygienist in alternative practice pursuant to Sections 1768 and 1770 of the Business and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist in alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of Section 1482 of the article.

(2) All providers enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.

(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

(s) In-home medical care services are covered when medically appropriate and subject to utilization controls, for beneficiaries who would otherwise require care for

an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to patients placed in shared or congregate living arrangements, if a home setting is not medically appropriate or available to the beneficiary. As used in this section, "in-home medical care service" includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

As used in this subdivision, in-home medical care services, include, but are not limited to:

(1) Level of care and cost of care evaluations.

(2) Expenses, directly attributable to home care activities, for materials.

(3) Physician fees for home visits.

(4) Expenses directly attributable to home care activities for shelter and modification to shelter.

(5) Expenses directly attributable to additional costs of special diets, including tube feeding.

(6) Medically related personal services.

(7) Home nursing education.

(8) Emergency maintenance repair.

(9) Home health agency personnel benefits which permit coverage of care during periods when regular personnel are on vacation or using sick leave.

(10) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.

(11) Emergency and nonemergency medical transportation.

(12) Medical supplies.

(13) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.

(14) Utility use directly attributable to the requirements of home care activities which are in addition to normal utility use.

(15) Special drugs and medications.

(16) Home health agency supervision of visiting staff which is medically necessary, but not included in the home health agency rate.

(17) Therapy services.

(18) Household appliances and household utensil costs directly attributable to home care activities.

(19) Modification of medical equipment for home use.

(20) Training and orientation for use of life-support systems, including, but not limited to, support of respiratory functions.

(21) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.

Beneficiaries receiving in-home medical care services are entitled to the full range of services within the Medi-Cal scope of benefits as defined by this section, subject to medical necessity and applicable utilization control. Services provided

pursuant to this subdivision, which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with a home- and community-based services waiver.

(t) Home- and community-based services approved by the United States Department of Health and Human Services may be covered to the extent that federal financial participation is available for those services under waivers granted in accordance with Section 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.

(u) Comprehensive perinatal services, as provided through an agreement with a health care provider designated in Section 14134.5 and meeting the standards developed by the department pursuant to Section 14134.5, subject to utilization controls.

The department shall seek any federal waivers necessary to implement the provisions of this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for the other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.

(v) Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(w) Hospice service which is Medicare-certified hospice service is covered, subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred.

(x) When a claim for treatment provided to a beneficiary includes both services which are authorized and reimbursable under this chapter, and services which are not reimbursable under this chapter, that portion of the claim for the treatment and services authorized and reimbursable under this chapter shall be payable.

(y) Home- and community-based services approved by the United States Department of Health and Human Services for beneficiaries with a diagnosis of AIDS or ARC, who require intermediate care or a higher level of care.

Services provided pursuant to a waiver obtained from the Secretary of the United States Department of Health and Human Services pursuant to this subdivision, and which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with the waiver, and subject to the terms, conditions, and duration of the waiver. These services shall be provided to individual beneficiaries in accordance with the client's needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.

The director may under this section contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to eligible

beneficiaries. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions Code, and as an in-home medical service as outlined in subdivision (s).

(aa) (1) There is hereby established in the department, a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Program.

(2) The department shall seek a waiver in accordance with Section 1315 of Title 42 of the United States Code, or a state plan amendment adopted in accordance with Section 1396a(a)(10)(A)(ii)(XXI)(ii)(2) of Title 42 of the United States Code, which was added to Section 1396a of Title 42 of the United States Code by Section 2303(a)(2) of the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), for a program to provide comprehensive clinical family planning services as described in paragraph (8). Under the waiver, the program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. Under the state plan amendment, which shall replace the waiver and shall be known as the Family PACT successor state plan amendment, the program shall be operated only in accordance with this subdivision and the statutes and regulations in paragraph (4). The state shall

use the standards and processes imposed by the state on January 1, 2007, including the application of an eligibility discount factor to the extent required by the federal Centers for Medicare and Medicaid Services, for purposes of determining eligibility as permitted under Section 1396a(a)(10)(A)(ii)(XXI)(ii)(2) of Title 42 of the United States Code. To the extent that federal financial participation is available, the program shall continue to conduct education, outreach, enrollment, service delivery, and evaluation services as specified under the waiver. The services shall be provided under the program only if the waiver and, when applicable, the successor state plan amendment are approved by the federal Centers for Medicare and Medicaid Services and only to the extent that federal financial participation is available for the services. Nothing in this section shall prohibit the department from seeking the Family PACT successor state plan amendment during the operation of the waiver.

(3) Solely for the purposes of the waiver or Family PACT successor state plan amendment and notwithstanding any other provision of law, the collection and use of an individual's social security number shall be necessary only to the extent required by federal law.

(4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005, and 24013, and any regulations adopted under these statutes shall apply to the program provided for under this subdivision. No other provision of law under the Medi-Cal program or the State-Only Family Planning Program shall apply to the program provided for under this subdivision.

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, without

taking regulatory action, the provisions of the waiver after its approval by the federal Health Care Financing Administration and the provisions of this section by means of an all-county letter or similar instruction to providers. Thereafter, the department shall adopt regulations to implement this section and the approved waiver in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of the act adding this subdivision, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(6) In the event that the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) or the Family PACT successor state plan amendment is no longer cost effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no share of cost, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either

if they are eligible for Medi-Cal with a share of cost or if they are otherwise eligible under Section 24003.

(8) For purposes of this subdivision, "comprehensive clinical family planning services" means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family planning services shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, and followup,

consultation, and referral services, as indicated, which may require treatment authorization requests.

(B) All United States Department of Agriculture, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(C) Culturally and linguistically appropriate health education and counseling services, including informed consent, that include all of the following:

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

(x) Use of contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies.

(xi) Possible contraceptive consequences and followup.

(xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(D) A comprehensive health history, updated at the next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history,

gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

(E) A complete physical examination on initial and subsequent periodic visits.

(F) Services, drugs, devices, and supplies deemed by the federal Centers for Medicare and Medicaid Services to be appropriate for inclusion in the program.

(9) In order to maximize the availability of federal financial participation under this subdivision, the director shall have the discretion to implement the Family PACT successor state plan amendment retroactively to July 1, 2010.

(ab) (1) Purchase of prescribed enteral ~~formulae~~ nutrition products is covered, subject to the Medi-Cal list of enteral ~~formulae~~ nutrition products and utilization controls.

(2) Purchase of enteral nutrition products for persons 21 years of age and older is limited to those products to be administered through a gastric, nasogastric, or jejunostomy tube.

(3) Notwithstanding paragraph (2), the department may deem a complete or incomplete enteral nutrition product, not administered through a gastric, nasogastric, or jejunostomy tube, a benefit for patients with diagnoses, including, but not limited to, malabsorption and inborn errors of metabolism, if the product appropriately lacks only an offending nutrient, or has not been shown to be investigational or experimental when used as part of a therapeutic regimen to prevent serious disability or death.

(4) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the amendments to this subdivision made by the act that added this paragraph by means

of all-county letters, provider bulletins, or similar instructions, without taking regulatory action.

(5) The amendments made to this subdivision by the act that added this paragraph shall be implemented 60 days after mailing of the beneficiary notification letter and no sooner than June 1, 2011.

(ac) Diabetic testing supplies are covered when provided by a pharmacy, subject to utilization controls.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary for implementation of the Budget Act of 2011, it is necessary that this act take effect immediately.

- 0 -

An act to amend Section 14133.22 of the Welfare and Institutions Code, relating to Medi-Cal, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Medi-Cal: prescription drugs.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law limits the number of prescription drugs that a Medi-Cal beneficiary may receive under the Medi-Cal program to 6 per month, unless prior authorization is received. Existing law provides an exception from the limit on prescription drugs for patients receiving care in a nursing facility and for drugs for family planning.

This bill would remove the prior authorization requirement and, instead, provide an exception from the limit on prescription drugs for patients receiving care in a nursing facility, patients receiving pregnancy-related services, children under 21 years of age, and any drug specifically exempted by the department, as provided.

This bill would provide that these provisions shall be implemented on the first day of the calendar month following 210 days after the effective date of this act. This bill would require the department to seek any necessary federal approvals for the implementation of these provisions and would provide that these provisions shall only be implemented to the extent that federal approval is obtained.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14133.22 of the Welfare and Institutions Code is amended to read:

14133.22. (a) (1) Prescribed drugs shall be limited to no more than six per month, unless prior authorization is obtained.

~~(b)~~

(2) The limit in ~~subdivision (a)~~ paragraph (1) shall not apply to patients receiving care in a nursing facility.

~~(c)~~

(3) The limit in ~~subdivision (a)~~ paragraph (1) shall not apply to drugs for family planning.

~~(d)~~

(4) The department may issue Medi-Cal cards that contain labels for prescribed drugs to implement this section.

~~(e)~~

(5) In carrying out this ~~section~~ subdivision, the department may contract either directly, or through the fiscal intermediary, for pharmacy consultant staff necessary to accomplish the treatment authorization request reviews.

(b) Subdivision (a) shall cease to be implemented on the date subdivision (c) is implemented pursuant to subdivisions (d) and (e).

(c) (1) Prescribed drugs shall be limited to no more than six per month.

(2) The limit in paragraph (1) shall not apply to the following:

(A) Patients receiving care in a nursing facility, patients receiving pregnancy-related services, or children under 21 years of age.

(B) Any drug specifically exempted from paragraph (1) by the department. Any exemption of a drug shall be established by the department in accordance with the purposes of the Medi-Cal program and shall be subject to utilization controls.

(d) Subdivision (c) shall be implemented on the first day of the calendar month following 210 days after the effective date of the act that added this subdivision.

(e) The director shall implement subdivision (c) in a manner that is consistent with federal Medicaid law and regulations. The director shall seek any necessary federal approvals for the implementation of subdivision (c). Subdivision (c) shall be implemented only to the extent that federal approval is obtained.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement subdivision (c) by means of all-county letters, provider bulletins, policy letters, or similar instructions, without taking regulatory action.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary for implementation of the Budget Act of 2011, it is necessary that this act take effect immediately.

- 0 -

An act to amend Sections 14167.1, 14167.4, 14167.6, 14167.9, 14167.11, 14167.13, 14167.14, 14167.17, 14167.31, 14167.32, 14167.354, 14167.36, 14167.40, and 14167.41 of, and to add Sections 14167.171 and 14167.391 to, the Welfare and Institutions Code, relating to Medi-Cal, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Medi-Cal: hospitals: quality assurance fee: supplemental payments.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions.

Existing law, subject to federal approval, imposes a quality assurance fee, as specified, on certain general acute care hospitals through and including December 31, 2010. Existing law creates the Hospital Quality Assurance Revenue Fund in the State Treasury and requires that the money collected from the quality assurance fee be deposited into the fund.

Existing law, subject to federal approval, requires the department to make supplemental payments for certain services, as specified, to private hospitals, nondesignated public hospitals, and designated public hospitals, as defined, for subject

fiscal years, as defined. Existing law also requires the department to increase capitation payments to Medi-Cal managed care plans and increase payments to mental health plans as specified. Existing law provides that the moneys in the Hospital Quality Assurance Revenue Fund shall, upon appropriation by the Legislature, be available only for certain purposes, including providing the above-described supplemental payments to hospitals, increased capitation payments to Medi-Cal managed care plans, and increased payments to mental health plans.

This bill would extend the imposition of the quality assurance fee, the payment of the supplemental payments, and the payment of increased payments to Medi-Cal managed care plans and mental health plans through June 30, 2011. This bill would also make other conforming changes.

Existing law provides that it creates a contractually enforceable promise on behalf of the state to use the proceeds of the quality assurance fee as specified.

This bill would delete this provision.

Existing law, effective January 1, 2011, and subject to the authority of a subsequent statute enacted to take effect on or after January 1, 2011, that meets certain conditions, imposes a quality assurance fee in a manner necessary to obtain federal Medicaid matching funds that shall be due and payable to the department by each general acute care hospital at specified rates for the purpose of making Medi-Cal payments to hospitals.

This bill would, instead, make these provisions effective July 1, 2011.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14167.1 of the Welfare and Institutions Code is amended to read:

14167.1. For purposes of this article, the following definitions shall apply:

(a) "Acute psychiatric days" means the total number of Short-Doyle administrative days, Short-Doyle acute care days, acute psychiatric administrative days, and acute psychiatric acute days identified in the Final Medi-Cal Utilization Statistics for the 2008–09 state fiscal year as calculated by the department on September 15, 2008.

(b) "Converted hospital" means a private hospital that becomes a designated public hospital or a nondesignated public hospital after the implementation date, a nondesignated public hospital that becomes a private hospital or a designated public hospital after the implementation date, or a designated public hospital that becomes a private hospital or a nondesignated public hospital after the implementation date.

(c) "Current Section 1115 Waiver" means California's Medi-Cal Hospital/Uninsured Care Section 1115 Waiver Demonstration in effect on the effective date of the article.

(d) "Designated public hospital" shall have the meaning given in subdivision (d) of Section 14166.1 as that section may be amended from time to time.

(e) "General acute care days" means the total number of Medi-Cal general acute care days paid by the department to a hospital in the 2008 calendar year, as reflected in the state paid claims files on July 10, 2009.

(f) "High acuity days" means Medi-Cal coronary care unit days, pediatric intensive care unit days, intensive care unit days, neonatal intensive care unit days, and burn unit days paid by the department during the 2008 calendar year, as reflected in the state paid claims files on July 10, 2009.

(g) "Hospital inpatient services" means all services covered under Medi-Cal and furnished by hospitals to patients who are admitted as hospital inpatients and reimbursed on a fee-for-service basis by the department directly or through its fiscal intermediary. Hospital inpatient services include outpatient services furnished by a hospital to a patient who is admitted to that hospital within 24 hours of the provision of the outpatient services that are related to the condition for which the patient is admitted. Hospital inpatient services do not include services for which a managed health care plan is financially responsible.

(h) "Hospital outpatient services" means all services covered under Medi-Cal furnished by hospitals to patients who are registered as hospital outpatients and reimbursed by the department on a fee-for-service basis directly or through its fiscal intermediary. Hospital outpatient services do not include services for which a managed health care plan is financially responsible, or services rendered by a hospital-based federally qualified health center for which reimbursement is received pursuant to Section 14132.100.

(i) (1) "Implementation date" means the latest effective date of all federal approvals or waivers necessary for the implementation of this article and Article 5.22 (commencing with Section 14167.31), including, but not limited to, any approvals on amendments to contracts between the department and managed health care plans or

(i) Article 2.7 (commencing with Section 14087.3).

(ii) Article 2.8 (commencing with Section 14087.5).

(iii) Article 2.81 (commencing with Section 14087.96).

(iv) Article 2.91 (commencing with Section 14089).

(B) Managed health care plans do not include any of the following:

(i) Mental health plan contracting to provide mental health care for Medi-Cal beneficiaries pursuant to Part 2.5 (commencing with Section 5775) of Division 5.

(ii) Health plan not covering inpatient services such as primary care case management plans operating pursuant to Section 14088.85.

(iii) Long-Term Care Demonstration Projects for All-Inclusive Care for the Elderly operating pursuant to Chapter 8.75 (commencing with Section 14590).

(*l*) "Medi-Cal managed care days" means the total number of general acute care days, including well baby days, listed for the county organized health system and prepaid health plans identified in the Final Medi-Cal Utilization Statistics for the 2008–09 state fiscal year, as calculated by the department on September 15, 2008, except that the general acute care days, including well baby days, for the Santa Barbara Health Care Initiative shall be derived from the Final Medi-Cal Utilization Statistics for the 2007–08 state fiscal year.

(m) "Medicaid inpatient utilization rate" means Medicaid inpatient utilization rate as defined in Section 1396r-4 of Title 42 of the United States Code and as set forth in the final disproportionate share hospital eligibility list for the 2008–09 state fiscal year released by the department on October 22, 2008.

mental health plans necessary for the implementation of this article. The effective date of a federal approval or waiver shall be the earlier of the stated effective date or the first day of the first quarter to which the computation of the payments or fee under the federal approval or waiver is applicable, which may be prior to the date that the federal approval or waiver is granted or the applicable contract is amended.

(2) If federal approval is sought initially for only the 2008–09 federal fiscal year and separately secured for subsequent federal fiscal years, the implementation date for the 2008–09 federal fiscal year shall occur when all necessary federal approvals have been secured for that federal fiscal year.

(j) "Individual hospital acute psychiatric supplemental payment" means the total amount of acute psychiatric hospital supplemental payments to a subject hospital for a quarter for which the supplemental payments are made. The "individual hospital acute psychiatric supplemental payment" shall be calculated for subject hospitals by multiplying the number of acute psychiatric days for the individual hospital for which a mental health plan was financially responsible by four hundred eighty-five dollars ($485) and dividing the result by 4.

(k) (1) "Managed health care plan" means a health care delivery system that manages the provision of health care and receives prepaid capitated payments from the state in return for providing services to Medi-Cal beneficiaries.

(2) (A) Managed health care plans include county organized health systems and entities contracting with the department to provide services pursuant to two-plan models and geographic managed care. Entities providing these services contract with the department pursuant to any of the following:

(n) "Mental health plan" means a mental health plan that contracts with the State Department of Mental Health to furnish or arrange for the provision of mental health services to Medi-Cal beneficiaries pursuant to Part 2.5 (commencing with Section 5775) of Division 5.

(o) "New hospital" means a hospital that was not in operation under current or prior ownership as a private hospital, a nondesignated public hospital, or a designated public hospital for any portion of the 2008–09 state fiscal year.

(p) "Nondesignated public hospital" means either of the following:

(1) A public hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's annual financial disclosure report for the hospital's latest fiscal year ending in 2007, and satisfies the definition in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(2) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's annual financial disclosure report for the hospital's latest fiscal year ending in 2007, is operating a hospital owned by a local health care district, and is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member.

(q) "Outpatient base amount" means the total amount of payments for hospital outpatient services made to a hospital in the 2007 calendar year, as reflected in state paid claims files on January 26, 2008.

(r) "Private hospital" means a hospital that meets all of the following conditions:

(1) Is licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.

(2) Is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, or is not designated as a specialty hospital in the hospital's Office of Statewide Health Planning and Development Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2007.

(3) Does not satisfy the Medicare criteria to be classified as a long-term care hospital.

(4) Is a nonpublic hospital, nonpublic converted hospital, or converted hospital as those terms are defined in paragraphs (26) to (28), inclusive, respectively, of subdivision (a) of Section 14105.98.

(s) "Subject federal fiscal year" means a federal fiscal year that ends after the implementation date and begins before ~~December 31, 2010~~ June 30, 2011.

(t) "Subject fiscal quarter" means a fiscal quarter beginning on or after the implementation date and ending before ~~January~~ July 1, 2011.

(u) "Subject fiscal year" means a state fiscal year that ends after the implementation date and begins before ~~December 31, 2010~~ June 30, 2011.

(v) "Subject hospital" shall mean a hospital that meets all of the following conditions:

(1) Is licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.

(2) Is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, or is not designated as a

specialty hospital in the hospital's Office of Statewide Health Planning and Development Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2007.

(3) Does not satisfy the Medicare criteria to be classified as a long-term care hospital.

(w) "Subject month" means a calendar month beginning on or after the implementation date and ending before ~~January~~ July 1, 2011.

(x) "Upper payment limit" means a federal upper payment limit on the amount of the Medicaid payment for which federal financial participation is available for a class of service and a class of health care providers, as specified in Part 447 of Title 42 of the Code of Federal Regulations.

SEC. 2. Section 14167.4 of the Welfare and Institutions Code is amended to read:

14167.4. (a) Nondesignated public hospitals shall be paid supplemental amounts for the provision of hospital inpatient services as set forth in this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services and shall not affect any other payments to hospitals.

(b) Except as set forth in subdivisions (f) and (g), each nondesignated public hospital shall be paid the following amounts for each subject fiscal year:

(1) Two hundred eighteen dollars and eighty-two cents ($218.82) multiplied by the hospital's general acute care days.

(2) Four hundred eighty-five dollars ($485) multiplied by the hospital's acute psychiatric days that were paid directly by the department and were not the financial responsibility of a mental health plan.

(c) In the event federal financial participation for a subject fiscal year is not available for all of the supplemental amounts payable to nondesignated public hospitals under subdivision (b) due to the application of a federal upper payment limit or for any other reason, both of the following shall apply:

(1) The total amount payable to nondesignated public hospitals under subdivision (b) for the subject fiscal year shall be reduced to the amount for which federal financial participation is available.

(2) The amount payable under subdivision (b) to each nondesignated public hospital for the subject fiscal year shall be equal to the amount computed under subdivision (b) multiplied by the ratio of the total amount for which federal financial participation is available to the total amount computed under subdivision (b).

(d) In the event the amount otherwise payable to a hospital under this section for a subject fiscal year exceeds the amount for which federal financial participation is available for that hospital, the amount due to the hospital for that federal fiscal year shall be reduced to the amount for which federal financial participation is available.

(e) The amounts set forth in this section are inclusive of federal financial participation.

(f) No payments shall be made under this section to a new hospital.

(g) (1) No payments shall be made under this section to a converted hospital for the portion of the subject fiscal year that begins on October 1 and ends on June 30 for the subject fiscal year that includes the first day of the subject federal fiscal year in which the hospital becomes a converted hospital, and for all subsequent subject fiscal years. In the event of a conflict between the provisions of this subdivision and the terms

of a state plan amendment required for receipt of approval by the federal Centers for Medicare and Medicaid Services, the state plan amendment shall control.

(2) Notwithstanding paragraph (1), the director shall seek federal approval to allow payments to be made under this section for the period beginning July 1, 2010, and ending ~~June 30~~ December 31, 2011, to a converted hospital which is a hospital described in paragraph (2) of subdivision (p) of Section 14167.1, and shall make payments under this section consistent with any approvals, subject to all of the following:

(A) Federal approval shall be sought after all final federal approvals necessary to implement this article and Article 5.22 (commencing with Section 14167.31) are received by the department.

(B) The director shall have determined prior to seeking federal approval that obtaining federal approval and implementing the payments described in this paragraph will not jeopardize the implementation of this article or Article 5.22 (commencing with Section 14167.31), or delay any payments to hospitals and managed health care plans under this article or Article 5.22 (commencing with Section 14167.31), or the collection of the quality assurance fee from hospitals under Article 5.22 (commencing with Section 14167.31), beyond ~~December 31, 2010~~ June 30, 2011.

(C) The director shall withdraw any request for federal approval made under this paragraph if, after submitting the request, the director has determined that obtaining federal approval and implementing the payments described in this paragraph will jeopardize the implementation of this article or Article 5.22 (commencing with Section 14167.31) or delay any payments to hospitals and managed health care plans under

this article or Article 5.22, (commencing with Section 14167.31) or the collection of the quality assurance fee from hospitals under Article 5.22, (commencing with Section 14167.31) beyond ~~December 31, 2010~~ June 30, 2011.

(h) In the event that the amounts payable as calculated under subdivision (b) for the 2008–09 subject fiscal year are reduced by the operation of subdivision (c) and the ratio for the 2008–09 subject fiscal year described in paragraph (2) of subdivision (c) is less than 0.25, the difference between 25 percent of the amounts payable as calculated under subdivision (b) and the amounts payable after the application of subdivision (c) shall be added to the supplemental payments for each nondesignated public hospital calculated under subdivision (b) for the 2009–10 subject fiscal year.

(i) In the event that the amounts payable as calculated under subdivision (b) for the 2009–10 subject fiscal year, including any carryover amounts determined under subdivision (h), are reduced by the operation of subdivision (c), the difference between the amounts payable as calculated under subdivision (b), including any carryover amounts, and the amounts payable after the application of subdivision (c) shall be added to the supplemental payments for each nondesignated public hospital calculated under subdivision (b) for the 2010–11 subject fiscal year.

SEC. 3. Section 14167.6 of the Welfare and Institutions Code is amended to read:

14167.6. (a) The department shall increase capitation payments to Medi-Cal managed health care plans for the subject fiscal years as set forth in this section.

(b) The increased capitation payments shall be made as part of the monthly capitated payments made by the department to managed health care plans.

(c) The aggregate amount of increased capitation payments to all Medi-Cal managed health care plans for all subject fiscal years shall be one billion two hundred seventy-seven million two hundred one thousand two hundred nine dollars ($1,277,201,209), or the maximum amount for which federal financial participation is available, whichever is lower.

(d) The department shall determine the amount of the increased capitation payments for each managed health care plan. The department shall consider the composition of Medi-Cal enrollees in the plan, the anticipated utilization of hospital services by the plan's Medi-Cal enrollees, and other factors that the department determines are reasonable and appropriate to ensuring access to high-quality hospital services by the plan's enrollees.

(e) The amount of increased capitation payments to each Medi-Cal managed care health plan shall not exceed an amount that results in capitation payments that are certified by the state's actuary as meeting federal requirements, taking into account the requirement that all of the increased capitation payments under this section shall be paid by the Medi-Cal managed health care plans to hospitals for hospital services to Medi-Cal enrollees of the plan.

(f) (1) The increased capitation payments to managed health care plans under this section shall be made to support the availability of hospital services and ensure access to hospital services for Medi-Cal beneficiaries. The increased capitation payments to managed health care plans shall commence no later than ~~December 31, 2010~~ June 30, 2011, and shall include, but not be limited to, the sum of the increased payments for all prior months for which payments are due.

(2) To secure the necessary funding for the payment or payments made pursuant to paragraph (1), the department may accumulate funds in the Hospital Quality Assurance Fee Fund for the purpose of funding managed care capitation payments under this article regardless of the date on which capitation payments are scheduled to be paid in order to secure the necessary total funding for managed care payments by ~~December 1, 2010~~ June 1, 2011. ~~To the extent feasible, the funds shall be accumulated as follows, provided that the department may adjust the following dates and amounts as necessary to accumulate sufficient funding by December 1, 2010:~~

~~(A) Thirty percent of total necessary funding shall be accumulated from each of the first three installments of quality assurance fees received from the hospitals.~~

~~(B) Ten percent of total funding necessary shall be retained from the fourth installment of quality assurance fees received from the hospitals.~~

(g) Payments to managed health care plans that would be paid consistent with actuarial certification and enrollment in the absence of the payments made pursuant to this section shall not be reduced as a consequence of payment under this section.

(h) (1) Each managed health care plan shall expend 100 percent of any increased capitation payments it receives under this section, on hospital services.

(2) The department may issue change orders to amend contracts with managed health care plans as needed to adjust monthly capitation payments in order to implement this section.

(3) For entities contracting with the department pursuant to Article 2.91 (commencing with Section 14089), any incremental increase in capitation rates pursuant

to this section shall not be subject to negotiation and approval by the California Medical Assistance Commission.

(i) In the event federal financial participation is not available for all of the increased capitation payments determined for a month pursuant to this section for any reason, the increased capitation payments mandated by this section for that month shall be reduced proportionately to the amount for which federal financial participation is available.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of policy letters or similar instructions, without taking further regulatory action.

SEC. 4. Section 14167.9 of the Welfare and Institutions Code is amended to read:

14167.9. Subject to the limitations in Section 14167.14, the following shall apply:

(a) (1) ~~The~~ Subject to paragraph (2), the department shall make ~~to hospitals~~ the payments to hospitals as described in Sections 14167.2, 14167.3, 14167.4, and subdivision (d) of Section 14167.5 for the 2008–09, 2009–10, and 2010–11 subject fiscal years ~~in seven payments~~ as scheduled by the director.

~~(2) (A) The first payment shall be made on or before the later of September 30, 2010, or the 30th day after the notice described in Section 14167.32 is sent to each hospital.~~

~~(B) The subsequent payments shall be made in six consecutive semimonthly payments that shall be made on or before the later of each of the 14th and 30th days of October, November, and December 2010, or the 30th day after the notice described in Section 14167.32 is sent to each hospital.~~

~~(3) The amount of each payment made pursuant to this subdivision shall be one-seventh of the amount of payments calculated for each hospital under Sections 14167.2, 14167.3, 14167.4, and subdivision (d) of Section 14167.5.~~

(2) The last payment shall be made by June 30, 2011.

(b) Notwithstanding subdivision (a), all amounts due to hospitals under Sections 14167.2, 14167.3, 14167.4, and subdivision (d) of Section 14167.5 that have not been paid to hospitals before ~~December 30, 2010~~ June 30, 2011, pursuant to subdivision (a), shall be paid to hospitals no later than ~~December 30, 2010~~ June 30, 2011.

(c) ~~(1)~~ The department shall make ~~to hospitals~~ the payments to hospitals as described in subdivisions (a), (b), and (c) of Section 14167.5 ~~in seven payments~~ by June 30, 2011, as scheduled by the director.

~~(2) (A) (i) The first six payments shall be made in consecutive semimonthly payments that shall be made on or before the later of each of the first and 15th days of October, November, and December 2010, or the 30th day after the notice described in Section 14167.32 is sent to each hospital.~~

~~(ii) The amount of each of the first six payments shall be one-seventh of the amount of payments calculated for each hospital under subdivisions (a), (b), and (c) of Section 14167.5.~~

~~(B) (i) The seventh payment shall be made on or before December 30, 2010.~~

~~(ii) The amount of the seventh payment shall be the total amount due to hospitals under subdivisions (a), (b), and (c) of Section 14167.5 minus the amounts previously paid to the hospitals under subparagraph (A).~~

SEC. 5. Section 14167.11 of the Welfare and Institutions Code is amended to read:

14167.11. (a) The department shall increase payments to mental health plans for the subject fiscal years as set forth in this section. The aggregate amount of the increased payments for a subject fiscal quarter shall be the total of the individual hospital acute psychiatric supplemental payment amounts for all hospitals for which federal financial participation is available.

(b) For each subject fiscal quarter, the state shall make increased payments to each mental health plan. The department shall consider the composition of Medi-Cal enrollees in the mental health plan, the anticipated utilization of hospital services by the mental health plan's Medi-Cal enrollees, and other factors that the department determines are reasonable and appropriate to ensure access to high-quality hospital services by the mental health plan's enrollees.

(c) The state shall make increased payments to mental health plans exclusively for the purpose of making payments to hospitals, in order to support the availability of hospital mental health services and ensure access for Medi-Cal beneficiaries to hospital mental health services. The increased payments to mental health plans shall be made as follows:

(1) The increased payments shall commence on or before the later of the last day of the second month of the quarter in which federal approval is granted or the 45th

day following the day on which federal approval is granted. Subsequent increased payments shall be made on the last day of the second month of each quarter. The last increased payments made pursuant to this section shall be made ~~during November 2010~~ by May 2011.

(2) The increased payments made for the first quarter for which increased payments are made under this section shall include the sum of increased payments for all prior quarters for which payments are due under subdivision (b).

(3) The increased payments made ~~during November 2010~~ by May 2011 shall include payments computed under subdivision (b) for all quarters in the 2010–11 subject fiscal year to the extent that federal financial participation is available for the payments.

(4) If all necessary federal approvals are not received on or before September 1, 2010, the department shall make semimonthly payments starting within one month of receipt of all necessary federal approvals until ~~December 31, 2010~~ June 30, 2011.

(d) Each mental health plan shall expend, in the form of additional payments to hospitals, the increased payments it receives under this section, pursuant to Section 14167.12.

(e) In the event federal financial participation for a subject fiscal year is not available for all of the increased acute psychiatric payments determined for a quarter pursuant to this section for any reason, the increased payments mandated by this section for that quarter shall be reduced proportionately to the amount for which federal financial participation is available.

(f) Payments to mental health plans that would be paid in the absence of the payments made pursuant to this section shall not be reduced as a consequence of the payments under this section.

(g) Notwithstanding any other provision of this article or Article 5.22 (commencing with Section 14167.31), individual hospital acute psychiatric supplemental payments under this section and Section 14167.12 may be made directly by the department to hospitals in accordance with Section 14167.9 when federal law does not require that the payments be transmitted to the hospitals via mental health plans.

(h) The department may, as necessary, allocate money appropriated to it from the Hospital Quality Assurance Revenue Fund to the State Department of Mental Health for the purposes of making increased payments to mental health plans pursuant to this article.

(i) The amount, if any, by which the aggregate individual hospital acute psychiatric supplemental payment amounts for a subject fiscal quarter, including any carryover amount under this subdivision, exceeds the amount for which federal financial participation is available for that quarter due to the application of a federal upper payment limit shall be added to the aggregate individual hospital acute psychiatric supplemental payment amounts for the succeeding subject fiscal quarter. In the event there is a carryover amount for the subject fiscal quarter ending December 31, 2010, the amount shall be payable under this section for the quarter ending March 31, 2011, and, if necessary due to the application of a federal upper payment limit, the quarter ending June 30, 2011.

SEC. 6. Section 14167.13 of the Welfare and Institutions Code is amended to read:

14167.13. (a) Payment rates for hospital outpatient services, furnished by private hospitals, nondesignated public hospitals, and designated public hospitals before ~~January~~ July 1, 2011, exclusive of amounts payable under this article, shall not be reduced below the rates in effect on the effective date of this article.

(b) Rates payable to hospitals for hospital inpatient services furnished before ~~January~~ July 1, 2011, under contracts negotiated pursuant to the Selective Provider Contracting Program shall not be reduced below the contract rates in effect on the effective date of this article. This subdivision shall not prohibit changes to the supplemental payments paid to individual hospitals under Sections 14166.12, 14166.17, and 14166.23. The aggregate supplemental payments under Sections 14166.12, 14166.17, and 14166.23 that are not derived from the funding made available under Section 14166.20, or intergovernmental transfers described in paragraph (4) of subdivision (d) of Section 14166.12, and paragraph (4) of subdivision (d) of Section 14166.17, for the 2009–10 and 2010–11 state fiscal years, shall not be less than the aggregate payments under each of these sections during the 2008–09 state fiscal year that are not derived from the funding made available under Section 14166.20, or intergovernmental transfers described in paragraph (4) of subdivision (d) of Section 14166.12, and paragraph (4) of subdivision (d) of Section 14166.17.

(c) Payments to private hospitals and nondesignated public hospitals for hospital inpatient services furnished before ~~January~~ July 1, 2011, that are not reimbursed under a contract negotiated pursuant to the Selective Provider Contracting Program, exclusive

of amounts payable under this article, shall not be less than the amount of payments that would have been made under the payment methodology in effect on the effective date of this article.

(d) Payments to hospitals under Sections 14166.6, 14166.11, and 14166.16 for the 2009–10 and 2010–11 state fiscal years shall not be less than the payments due under the methodology set forth in those sections in effect on the effective date of this article.

(e) Reimbursement to designated public hospitals, or the governmental units with which they are affiliated, for services furnished before ~~January~~ July 1, 2011, pursuant to Sections 14166.4 and 14166.7, shall not be reduced below the level of reimbursement provided for in the applicable methodologies in effect on the effective date of this article.

(f) Payments for subacute services furnished by private hospitals, nondesignated public hospitals, and designated public hospitals before ~~January~~ July 1, 2011, exclusive of amounts payable under this article, shall not be reduced below the payments that would be made under rates or methodologies in effect on the effective date of this article.

(g) Solely for purposes of this article, a rate reduction or a change in a rate methodology made on or before the effective date of this article that is enjoined by a court shall be included in the determination of a rate or a rate methodology in effect on the effective date of this article until all appeals or judicial review have been exhausted and the rate reduction or change in rate methodology has been permanently enjoined or otherwise permanently prevented from being implemented.

SEC. 7. Section 14167.14 of the Welfare and Institutions Code is amended to read:

14167.14. (a) The director shall do all of the following:

(1) Submit any state plan amendment or waiver request that may be necessary to implement this article.

(2) Seek federal approval for the use of the entire federal upper payment limits applicable to hospital services for payments under this article for the 2008–09, 2009–10, and 2010–11 subject fiscal years.

(3) Seek federal approvals or waivers as may be necessary to implement this article and to obtain federal financial participation to the maximum extent possible for the payments under this article.

(4) Amend the contracts between the managed health care plans and the department as necessary to incorporate the provisions of Sections 14167.6 and 14167.10 and promptly seek all necessary federal approvals of those amendments. The department shall pursue amendments to the contracts as soon as possible after the effective date of this article and Article 5.22 (commencing with Section 14167.31), and shall not wait for federal approval of this article or Article 5.22 (commencing with Section 14167.31) prior to pursuing amendments to the contracts. The amendments to the contracts shall, among other provisions, set forth an agreement to increase payment rates to managed health care plans under Section 14166.6 and increase payments to hospitals under Section 14166.10 effective April 2009 or as soon thereafter as possible, conditioned on obtaining all federal approvals necessary for federal financial participation for the increased capitation payments to the managed health care plans.

(b) In implementing this article, the department may utilize the services of the Medi-Cal fiscal intermediary through a change order to the fiscal intermediary contract to administer this program, consistent with the requirements of Sections 14104.6, 14104.7, 14104.8, and 14104.9. Contracts entered into for purposes of implementing this article or Article 5.22 (commencing with Section 14167.31) shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

(c) This article shall become inoperative if either of the following occurs:

(1) In the event, and on the effective date, of a final judicial determination made by any court of appellate jurisdiction or a final determination by the federal Department of Health and Human Services or the federal Centers for Medicare and Medicaid Services that any element of this article cannot be implemented.

(2) In the event both of the following conditions exist:

(A) The federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before ~~January~~ July 1, 2012, the implementation of Article 5.22 (commencing with Section 14167.31) or this article.

(B) Either or both articles cannot be modified by the department pursuant to subdivision (e) of Section 14167.35 in order to meet the requirements of federal law or to obtain federal approval.

(d) If this article becomes inoperative pursuant to paragraph (1) of subdivision (c) and the determination applies to any period or periods of time prior to the effective date of the determination, the department shall have authority to recoup all payments made pursuant to this article during that period or those periods of time.

(e) In the event any hospital, or any party on behalf of a hospital, shall initiate a case or proceeding in any state or federal court in which the hospital seeks any relief of any sort whatsoever, including, but not limited to, monetary relief, injunctive relief, declaratory relief, or a writ, based in whole or in part on a contention that any or all of this article is unlawful and may not be lawfully implemented, both of the following shall apply:

(1) No payments shall be made to the hospital pursuant to this article until the case or proceeding is finally resolved, including the final disposition of all appeals.

(2) Any amount computed to be payable to the hospital pursuant to this section for a project year shall be withheld by the department and shall be paid to the hospital only after the case or proceeding is finally resolved, including the final disposition of all appeals.

(f) Subject to Section 14167.352, no payment shall be made under this article until all necessary federal approvals for the payment and for the fee provisions in Article 5.22 (commencing with Section 14167.31) have been obtained and the fee has been imposed and collected. Notwithstanding any other provision of law, payments under this article shall be made only to the extent that the fee established in Article 5.22 (commencing with Section 14167.31) is collected and available to cover the nonfederal share of the payments.

(g) Supplemental payments for the 2008–09 federal fiscal year shall not reduce the maximum federal funds available annually pursuant to the Special Terms and Conditions, as amended October 5, 2007, of the ~~Current~~ Section 1115 Waiver in effect at that time.

(h) (1) The director shall negotiate the federal approvals required to implement this article and Article 5.22 (commencing with Section 14167.31) for the 2009–10 and 2010–11 federal fiscal years concurrently with the negotiation of a federal waiver that will replace the Current Section 1115 Waiver, with a goal of obtaining federal approvals that do not adversely impact the federal funds that would otherwise be available for services to Medi-Cal beneficiaries and the uninsured. The director may initiate the concurrent negotiations required by this subdivision by submitting a concept paper to the federal Centers for Medicare and Medicaid Services outlining the key elements of the replacement waiver consistent with the goals set forth in this subdivision.

(2) In negotiating the terms of a federal waiver that will replace the Current 1115 Waiver, the department shall explore opportunities for reform of the Medi-Cal program and strengthen California's health care safety net. Subject to subsequent legislative approval, the department shall explore program reforms, that may include, but need not be limited to, strategies to accomplish payment system reforms for hospital inpatient and outpatient care, including incentive based payments, new payment methodologies such as diagnostic-related group-based (DRG-based), or similar methodologies, patient safety protocols, and quality measurement.

(3) This article and Article 5.22 (commencing with Section 14167.31) shall not be implemented with respect to the 2009–10 and 2010–11 federal fiscal years until the earlier of April 30, 2010, or the date the federal government approves a federal waiver for a demonstration that will replace the ~~Current~~ Section 1115 Waiver in effect at that time.

(i) A hospital's receipt of payments under this article for services rendered prior to the effective date of this article is conditioned on the hospital's continued participation in Medi-Cal for at least 30 days after the effective date of this article.

(j) All payments made by the department to hospitals, managed health care plans, and mental health plans under this article shall be made only from the following:

(1) The quality assurance fee set forth in Article 5.22 (commencing with Section 14167.31) and due and payable on or before ~~December 31, 2010~~ June 30, 2011.

(2) Federal reimbursement and any other related federal funds.

SEC. 8. Section 14167.17 of the Welfare and Institutions Code is amended to read:

14167.17. This article shall remain in effect only until ~~January 1, 2013,~~ July 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before ~~January 1,~~ July 1, 2013, deletes or extends that date.

SEC. 9. Section 14167.171 is added to the Welfare and Institutions Code, to read:

14167.171. The Legislature finds and declares all of the following:

(a) It is the intent of the Legislature that payments made pursuant to this article shall continue through June 30, 2011.

(b) The department shall make payments through June 30, 2011, using the principles for calculating and administering the payments that are set forth in this article.

(c) The department shall seek any federal approvals necessary for the implementation of this article and shall seek approval to implement the amendments

made by the act that added this section retroactively if approval is not obtained by January 1, 2011.

(d) The department may modify the implementation of this article to the extent necessary to comply with federal law, to obtain federal approval, or to obtain federal financial participation.

SEC. 10. Section 14167.31 of the Welfare and Institutions Code is amended to read:

14167.31. For the purposes of this article, the following definitions shall apply:

(a) (1) "Aggregate annual quality assurance fee" means, with respect to a hospital that is not a prepaid health plan hospital, the sum of all of the following:

(A) The annual fee-for-service days for an individual hospital multiplied by the fee-for-service per diem quality assurance fee rate.

(B) The annual managed care days for an individual hospital multiplied by the managed care per diem quality assurance fee rate.

(C) The annual Medi-Cal days for an individual hospital multiplied by the Medi-Cal per diem quality assurance fee rate.

(2) "Aggregate annual quality assurance fee" means, with respect to a hospital that is a prepaid health plan hospital, the sum of all of the following:

(A) The annual fee-for-service days for an individual hospital multiplied by the fee-for-service per diem quality assurance fee rate.

(B) The annual managed care days for an individual hospital multiplied by the prepaid health plan hospital managed care per diem quality assurance fee rate.

(C) The annual Medi-Cal managed care days for an individual hospital multiplied by the prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate.

(D) The annual Medi-Cal fee-for-service days for an individual hospital multiplied by the Medi-Cal per diem quality assurance fee rate.

(3) "Aggregate quality assurance fee after the application of the fee percentage" shall be determined separately for each subject federal fiscal year and means the aggregate annual quality assurance fee multiplied by the fee percentage for the subject federal fiscal year.

(4) "Aggregate quality assurance fee" means the sum of the aggregate quality assurance fee after the application of the fee percentage for a hospital for each subject federal fiscal year.

(b) "Annual fee-for-service days" means the number of fee-for-service days of each hospital subject to the quality assurance fee in the 2007 calendar year, as reported on the days data source.

(c) "Annual managed care days" means the number of managed care days of each hospital subject to the quality assurance fee in the 2007 calendar year, as reported on the days data source.

(d) "Annual Medi-Cal days" means the number of Medi-Cal days of each hospital subject to the quality assurance fee in the 2007 calendar year, as reported on the days data source.

(e) "Converted hospital" shall mean a hospital described in subdivision (b) of Section 14167.1.

(f) "Days data source" means the following:

(1) For a hospital that did not submit an Annual Financial Disclosure Report to the Office of Statewide Health Planning and Development for a fiscal year ending during 2007, but submitted that report for a fiscal period ending in 2008 that includes at least 10 months of 2007, the Annual Financial Disclosure Report submitted by the hospital to the Office of Statewide Health Planning and Development for the fiscal period in 2008 that includes at least 10 months of 2007.

(2) For a hospital owned by Kaiser Foundation Hospitals that submitted corrections to reported patient days to the Office of Statewide Health Planning and Development for its fiscal year ending in 2007 before July 31, 2009, the corrected data.

(3) For all other hospitals, the hospital's Annual Financial Disclosure Report in the Office of Statewide Health Planning and Development files as of October 31, 2008, for its fiscal year ending during 2007.

(g) "Designated public hospital" shall have the meaning given in subdivision (d) of Section 14166.1 as that section may be amended from time to time.

(h) "Exempt facility" means any of the following:

(1) A public hospital, which shall include either of the following:

(A) A hospital, as defined in paragraph (25) of subdivision (a) of Section 14105.98.

(B) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code and operating a hospital owned by a local health care district, and is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member.

(2) With the exception of a hospital that is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, a hospital that is a hospital designated as a specialty hospital in the hospital's Office of Statewide Health Planning and Development Hospital Annual Disclosure Report for the hospital's fiscal year ending in the 2007 calendar year.

(3) A hospital that satisfies the Medicare criteria to be a long-term care hospital.

(4) A small and rural hospital as specified in Section 124840 of the Health and Safety Code designated as that in the hospital's Office of Statewide Health Planning and Development Hospital Annual Disclosure Report for the hospital's fiscal year ending in the 2007 calendar year.

(i) (1) "Federal approval" means the last approval by the federal government required for the implementation of this article and Article 5.21 (commencing with Section 14167.1).

(2) If federal approval is sought initially for only the 2008–09 federal fiscal year and separately secured for subsequent federal fiscal years, the implementation date, as defined in subdivision (i) of Section 14167.1, for the 2008–09 federal fiscal year shall occur when all necessary federal approvals have been secured for that federal fiscal year.

(j) "Fee-for-service per diem quality assurance fee rate" means a fixed fee on fee-for-service days of two hundred fifteen dollars and thirty cents ($215.30) per day.

(k) "Fee-for-service days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric care," and "chemical dependency care and rehabilitation care," and the payer category is reported as "Medicare traditional,"

"county indigent programs–traditional," "other third parties–traditional," "other indigent," and "other payers," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(*l*) "Fee percentage" means, for each subject federal fiscal year, a fraction, expressed as a percentage, the numerator of which is the amount of payments for the subject federal fiscal year under Sections 14167.2, 14167.3, and 14167.4, subdivision (d) of Section 14167.5, and Sections 14167.6 and 14167.11, including payments made directly to hospitals pursuant to subdivision (g) of Section 14167.11, for which federal financial participation is available and the denominator of which is two billion nine hundred eighty-two million one hundred twenty thousand five hundred sixty dollars ($2,982,120,560).

(m) "General acute care hospital" means any hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.

(n) "Hospital community" means any hospital industry organization or system that represents children's hospitals, nondesignated public hospitals, designated public hospitals, private safety-net hospitals, and other public or private hospitals.

(o) "Managed care days" means inpatient hospital days as reported on the days data source where the service type is reported as "acute care," "psychiatric care," and "chemical dependency care and rehabilitation care," and the payer category is reported as "Medicare managed care," "county indigent programs–managed care," and "other third parties–managed care," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(p) "Managed care per diem quality assurance fee rate" means a fixed fee on managed care days of twenty-two dollars and fifty cents ($22.50) per day.

(q) "Medi-Cal days" means inpatient hospital days as reported on the days data source where the service type is reported as "acute care," "psychiatric care," and "chemical dependency care and rehabilitation care," and the payer category is reported as "Medi-Cal–traditional" and "Medi-Cal–managed care," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(r) "Medi-Cal fee-for-service days" means inpatient hospital days as reported on the days data source where the service type is reported as "acute care," "psychiatric care," and "chemical dependency care and rehabilitation care," and the payer category is reported as "Medi-Cal traditional" for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(s) "Medi-Cal managed care days" means inpatient hospital days as reported on the days data source where the service type is reported as "acute care," "psychiatric care," and "chemical dependency care and rehabilitation care," and the payer category is reported as "Medi-Cal managed care" for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(t) "Medi-Cal per diem quality assurance fee rate" means a fixed fee on Medi-Cal days of two hundred thirty-two dollars ($232) per day.

(u) "Nondesignated public hospital" means either of the following:

(1) A public hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's annual financial disclosure report for the hospital's latest fiscal year ending in 2007, and satisfies the definition in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(2) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's annual financial disclosure report for the hospital's latest fiscal year ending in 2007, is operating a hospital owned by a local health care district, and is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member.

(v) "Prepaid health plan hospital" means a hospital owned by a nonprofit public benefit corporation that shares a common board of directors with a nonprofit health care service plan.

(w) "Prepaid health plan hospital managed care per diem quality assurance fee rate" means a fixed fee on non-Medi-Cal managed care days for prepaid health plan hospitals of twelve dollars and sixty cents ($12.60) per day.

(x) "Prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate" means a fixed fee on Medi-Cal managed care days for prepaid health plan hospitals of one hundred twenty-nine dollars and ninety-two cents ($129.92) per day.

(y) "Prior fiscal year data" means any data taken from sources that the department determines are the most accurate and reliable at the time the determination is made, or

may be calculated from the most recent audited data using appropriate update factors. The data may be from prior fiscal years, current fiscal years, or projections of future fiscal years.

(z) "Private hospital" means a hospital that meets all of the following conditions:

(1) Is licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.

(2) Is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, or is not designated as a specialty hospital in the hospital's Office of Statewide Health Planning and Development Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2007.

(3) Does not satisfy the Medicare criteria to be classified as a long-term care hospital.

(4) Is a nonpublic hospital, nonpublic converted hospital, or converted hospital as those terms are defined in paragraphs (26) to (28), inclusive, respectively, of subdivision (a) of Section 14105.98.

(aa) "Subject federal fiscal year" means a federal fiscal year ending after the implementation date, as defined in Section 14167.1, and beginning before ~~December 31, 2010~~ June 30, 2011.

(ab) "Subject fiscal quarter" means a state fiscal quarter ending after the implementation date, as defined in Section 14167.1, and beginning before ~~January~~ July 1, 2011.

(ac) "Subject fiscal year" means a state fiscal year ending after the implementation date, as defined in Section 14167.1, and beginning before ~~December 31, 2010~~ June 30, 2011.

(ad) "Upper payment limit" means a federal upper payment limit on the amount of the Medicaid payment for which federal financial participation is available for a class of service and a class of health care providers, as specified in Part 447 of Title 42 of the Code of Federal Regulations.

SEC. 11. Section 14167.32 of the Welfare and Institutions Code is amended to read:

14167.32. (a) There shall be imposed on each general acute care hospital that is not an exempt facility a quality assurance fee, provided that a quality assurance fee under this article shall not be imposed on a converted hospital for a subject federal fiscal year in which the hospital becomes a converted hospital or for subsequent federal fiscal years.

(b) The quality assurance fee shall be computed starting on the implementation date, as defined in Section 14167.1, and continue through and including ~~December 31, 2010~~ June 30, 2011.

(c) Subject to Section 14167.352, upon receipt of federal approval, the following shall become operative:

(1) Within 30 days following receipt of the notice of federal approval from the federal government, the department shall send notice to each hospital subject to the quality assurance fee, and publish on its Internet Web site, the following information:

(A) The date that the state received notice of federal approval.

(B) The fee percentage or percentages for each subject federal fiscal year.

(2) The notice to each hospital subject to the quality assurance fee shall also state the following:

(A) The aggregate quality assurance fee after the application of the fee percentage for each subject federal fiscal year.

(B) The aggregate quality assurance fee.

(C) The amount of each installment payment due from the hospital with respect to the aggregate quality assurance fee.

(D) The date on which each installment payment is due.

(3) (A) ~~The~~ Subject to subparagraph (B), the hospitals shall pay the aggregate quality assurance fee ~~in seven equal installments~~ as scheduled by the director.

~~(B) (i) The first installment payment shall be made on or before the later of September 14, 2010, or the 14th day after the notice described in this section is sent to each hospital.~~

~~(ii) The additional installment payments shall be made in six consecutive semimonthly payments that shall be due and payable on or before the later of each of the first and 15th days of October, November, and December 2010, or the 14th day after the notice described in this section is sent to each hospital.~~

(B) The last installment payment shall be made by June 15, 2011.

(4) Notwithstanding paragraph (3), the amount of each hospital's aggregate quality assurance fee that has not been paid by the hospital before ~~December 15, 2010~~ June 15, 2011, pursuant to paragraph (3), shall be paid by the hospital no later than ~~December 15, 2010~~ June 15, 2011.

(d) The quality assurance fee, as paid pursuant to this subdivision, shall be paid by each hospital subject to the fee to the department for deposit in the Hospital Quality Assurance Revenue Fund. Deposits may be accepted at any time and will be credited toward the fiscal year for which they were assessed.

(e) This section shall become inoperative if the federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before ~~January~~ July 1, 2012, the implementation of this article or Article 5.21 (commencing with Section 14167.1), and either or both articles cannot be modified by the department pursuant to subdivision (e) of Section 14167.35 in order to meet the requirements of federal law or to obtain federal approval.

(f) In no case shall the aggregate fees collected in a subject federal fiscal year pursuant to this section exceed the maximum percentage of the annual aggregate net patient revenue for hospitals subject to the fee that is prescribed pursuant to federal law and regulations as necessary to preclude a finding that an indirect guarantee has been created.

(g) (1) Interest shall be assessed on quality assurance fees not paid on the date due at the greater of 10 percent per annum or the rate at which the department assesses interest on Medi-Cal program overpayments to hospitals that are not repaid when due. Interest shall begin to accrue the day after the date the payment was due and shall be deposited in the Hospital Quality Assurance Revenue Fund.

(2) In the event that any fee payment is more than 60 days overdue, a penalty equal to the interest charge described in paragraph (1) shall be assessed and due for each month for which the payment is not received after 60 days.

(h) When a hospital fails to pay all or part of the quality assurance fee on or before the date that payment is due, the department may the following day immediately begin to deduct the unpaid assessment and interest owed from any Medi-Cal payments or other state payments to the hospital in accordance with Section 12419.5 of the Government Code until the full amount is recovered. All amounts, except penalties, deducted by the department under this subdivision shall be deposited in the Hospital Quality Assurance Revenue Fund. The remedy provided to the department by this section is in addition to other remedies available under law.

(i) The payment of the quality assurance fee shall not be considered as an allowable cost for Medi-Cal cost reporting and reimbursement purposes.

(j) The department shall work in consultation with the hospital community to implement the quality assurance fee.

~~(k) This subdivision creates a contractually enforceable promise on behalf of the state to use the proceeds of the quality assurance fee, including any federal matching funds, solely and exclusively for the purposes set forth in this article as they existed on the effective date of this article, to limit the amount of the proceeds of the quality assurance fee to be used to pay for the health care coverage of children to the amounts specified in this article and to make any payments for the department's costs of administration to the amounts set forth in this article on the effective date of this article to maintain and continue prior reimbursement levels as set forth in Article 5.21 (commencing with Section 14167.1) on the effective date of that article, and to otherwise comply with all its obligations set forth in Article 5.21 (commencing with Section 14167.1) and this article provided that the following amendments to this article or~~

~~Article 5.21 (commencing with Section 14167.1) made during the 2010 portion of the 2009–10 Regular Session, or included in Senate Bill 208 of the 2009–10 Regular Session, shall control for purposes of this section:~~

~~(1) Amendments affecting the timing of the fee to be imposed or the payments to be made to a hospital or hospital group.~~

~~(2) Amendments affecting the amount of fee to be imposed on a hospital or hospital group, or the amount or method of payments to be made to any hospital or hospital group that are contained in Assembly Bill 1653, if enacted in the 2009–10 Regular Session, or arise from, or have as a basis, a decision, advice, or determination by the federal Centers for Medicare and Medicaid Services relating to federal approval of the quality assurance fee or the payments set forth in this article or Article 5.21 (commencing with Section 14167.1).~~

~~(3) Amendments modifying the priority given to Medi-Cal managed care payments.~~

~~(4) Amendments modifying the responsibility of nonexempt hospitals to make fee payments.~~

~~(l)~~

(k) For the purpose of this article, references to the receipt of notice by the state of federal approval of the implementation of this article shall refer to the last date that the state receives notice of all federal approval or waivers required for implementation of this article and Article 5.21 (commencing with Section 14167.1), subject to Section 14167.14.

~~(m)~~

(l) (1) Effective ~~January~~ July 1, 2011, the rates payable to hospitals and managed health care plans under Medi-Cal shall be the rates then payable without the supplemental and increased capitation payments set forth in Article 5.21 (commencing with Section 14167.1).

(2) The supplemental payments and other payments under Article 5.21 (commencing with Section 14167.1) shall be regarded as quality assurance payments, the implementation or suspension of which does not affect a determination of the adequacy of any rates under federal law.

~~(n)~~

(m) (1) Subject to paragraph (2), the director may waive any or all interest and penalties assessed under this article in the event that the director determines, in his or her sole discretion, that the hospital has demonstrated that imposition of the full quality assurance fee on the timelines applicable under this article has a high likelihood of creating a financial hardship for the hospital or a significant danger of reducing the provision of needed healthcare services.

(2) Waiver of some or all of the interest or penalties under this subdivision shall be conditioned on the hospital's agreement to make fee payments, or to have the payments withheld from payments otherwise due from the Medi-Cal program to the hospital, on a schedule developed by the department that takes into account the financial situation of the hospital and the potential impact on services.

(3) A decision by the director under this subdivision shall not be subject to judicial review.

SEC. 12. Section 14167.354 of the Welfare and Institutions Code is amended to read:

14167.354. (a) (1) Upon receipt of a letter that indicates likely federal approval that the director determines is sufficient for implementation under Section 14167.352, or upon the receipt of all final federal approvals necessary for the implementation of this article and Article 5.21 (commencing with Section 14167.1), the following shall occur:

(A) To the maximum extent possible, and consistent with the availability of funds in the Hospital Quality Assurance Revenue Fund, the department shall make all of the payments under Sections 14167.2, 14167.3, 14167.4, 14167.6, and 14167.11, and subdivision (d) of Section 14167.5, including, but not limited to, supplemental payments and increased capitation payments, prior to ~~January~~ July 1, 2011.

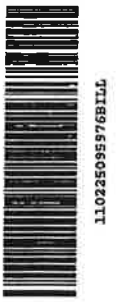
(B) The department shall make supplemental payments to hospitals under Article 5.21 (commencing with Section 14167.1) consistent with the timeframe described in Section 14167.9 or a modified timeline developed pursuant to Section 14167.353.

(2) (A) In determining the amount available for the nonfederal share of payments in a particular payment cycle, the department shall deduct no more than the following amounts to account for the priority payments to the state under paragraph (2) of subdivision (c) of Section 14167.35:

(i) Eighty million dollars ($80,000,000) for children's health coverage for each subject fiscal quarter for which some or all supplemental payments to hospitals have already been made.

(ii) Eighty million dollars ($80,000,000) for children's health coverage for each subject fiscal quarter for which supplemental payments are being calculated to be paid to hospitals, subject to the availability of funding, in the current payment cycle.

(B) Notwithstanding any other provision of law, in determining the amount available for the nonfederal share of payments in a payment cycle described in subparagraph (A), the department shall not consider any payments for children's health care coverage previously made under paragraph (2) of subdivision (c) of Section 14167.35.



(3) (A) In determining the amount available in a particular payment cycle, the department shall deduct no more than the following amounts whether made directly to the designated public hospitals or retained by the state:

(i) Seventy-three million seven hundred fifty thousand dollars ($73,750,000) for each subject fiscal quarter for which some or all supplemental payments to hospitals have already been made.

(ii) Seventy-three million seven hundred fifty thousand dollars ($73,750,000) for each subject fiscal quarter for which supplemental payments are being calculated to be paid to hospitals, subject to the availability of funding, in the current payment cycle.

(B) Notwithstanding any other provision of law, in determining the amount available for a payment cycle described in subparagraph (A), the department shall not consider any payments of direct grants previously made to the designated public hospitals or transferred to the state from the Hospital Quality Assurance Revenue Fund under Section 14167.5 to account for the direct grants described in Section 14167.5.

(b) Notwithstanding any other provision of this article or Article 5.21 (commencing with Section 14167.1), if the director determines, on or after December 15, 2010, that there are insufficient funds available in the Hospital Quality Assurance Revenue Fund to make all scheduled payments under Article 5.21 (commencing with Section 14167.1) by ~~the end of the 2010 calendar year~~ June 30, 2011, he or she shall consult with representatives of the hospital community to develop an acceptable plan for making additional payments to providers in the ~~first~~ last two quarters of 2011 to maximize the use of delinquent fee payments or other deposits or interest projected to become available in the fund after December 15, 2010, but before ~~June 30~~ December 31, 2011.

(c) Nothing in this section shall require the department to continue to make payments under Article 5.21 (commencing with Section 14167.1) if, after the consultation required under subdivision (b), the director determines in the exercise of his or her sole discretion that a workable plan for the continued payments cannot be developed.

(d) Subdivisions (b) and (c) shall be implemented only if and to the extent federal financial participation is available for continued supplemental payments to providers.

(e) If any payment or payments made pursuant to this section are found to be inconsistent with federal law, the department shall recoup the payments by means of withholding or any other available remedy.

(f) Nothing in this section shall be read as affecting the department's ongoing authority to continue, after ~~December 31, 2010~~ June 30, 2011, to collect quality assurance fees imposed on or before ~~December 31, 2010~~ June 30, 2011.

SEC. 13. Section 14167.36 of the Welfare and Institutions Code is amended to read:

14167.36. (a) This article shall only be implemented so long as the following conditions are met:

(1) Subject to Section 14167.35, the quality assurance fee is established in a manner that is fundamentally consistent with this article.

(2) The quality assurance fee, including any interest on the fee after collection by the department, is deposited in a segregated fund apart from the General Fund.

(3) The proceeds of the quality assurance fee, including any interest and related federal reimbursement, may only be used for the purposes set forth in this article.

(b) No hospital shall be required to pay the quality assurance fee to the department unless and until the state receives and maintains federal approval of the quality assurance fee and Article 5.21 (commencing with Section 14167.1) from the federal Centers for Medicare and Medicaid Services.

(c) Hospitals shall be required to pay the quality assurance fee to the department as set forth in this article only as long as all of the following conditions are met:

(1) The federal Centers for Medicare and Medicaid Services allows the use of the quality assurance fee as set forth in this article.

(2) Article 5.21 (commencing with Section 14167.1) is enacted and remains in effect and hospitals are reimbursed the increased rates beginning on the implementation date, as defined in Section 14167.1.

(3) The full amount of the quality assurance fee assessed and collected pursuant to this article remains available only for the purposes specified in this article.

(d) This article shall become inoperative if either of the following occurs:

(1) In the event, and on the effective date, of a final judicial determination made by any court of appellate jurisdiction or a final determination by the federal Department of Health and Human Services or the federal Centers for Medicare and Medicaid Services that any element of this article cannot be implemented.

(2) In the event both of the following conditions exist:

(A) The federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before ~~January~~ July 1, 2012, the implementation of Article 5.21 (commencing with Section 14167.1) or this article.

(B) Either or both articles cannot be modified by the department pursuant to subdivision (e) of Section 14167.35 in order to meet the requirements of federal law or to obtain federal approval.

(e) If this article becomes inoperative pursuant to paragraph (1) of subdivision (d) and the determination applies to any period or periods of time prior to the effective date of the determination, the department may recoup all payments made pursuant to Article 5.21 (commencing with Section 14167.1) during that period or those periods of time.

(f) This article and Article 5.21 (commencing with Section 14167.1) shall not be implemented with respect to the 2009–10 and 2010–11 federal fiscal years until the earlier of April 30, 2010, or the date the federal government approves a federal waiver for a demonstration that will replace the Current Section 1115 Waiver, as defined in subdivision (c) of Section 14167.1.

(g) (1) In the event that all necessary final federal approvals are not received as described and anticipated under this article or under Article 5.21 (commencing with Section 14167.1), the director shall have the discretion and authority to develop procedures for recoupment from managed health care plans, and from hospitals under contract with managed health care plans, of any amounts received pursuant to this article or Article 5.21 (commencing with Section 14167.1).

(2) Any procedure instituted pursuant to this subdivision shall be developed in consultation with representatives from managed health care plans and representatives of the hospital community.

(3) Any procedure instituted pursuant to this subdivision shall be in addition to all other remedies made available under the law, pursuant to contracts between the department and the managed health care plans, or pursuant to contracts between the managed health care plans and the hospitals.

SEC. 14. Section 14167.391 is added to the Welfare and Institutions Code, to read:

14167.391. The Legislature finds and declares all of the following:

(a) It is the intent of the Legislature that the quality assurance fee imposed on each general acute care hospital pursuant to this article shall continue through June 30, 2011.

(b) The department shall impose the quality assurance fee through June 30, 2011, using the principles for calculating and imposing the fee that are set forth in this article.

(c) The department shall seek any federal approvals necessary for the implementation of this article and shall seek approval to implement the amendments

made by the act that added this section retroactively if approval is not obtained by January 1, 2011.

(d) The department may modify the implementation of this article to the extent necessary to comply with federal law, to obtain federal approval, or to obtain federal financial participation.

SEC. 15. Section 14167.40 of the Welfare and Institutions Code is amended to read:

14167.40. This article shall remain in effect only until ~~January 1, 2013,~~ July 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before ~~January 1,~~ July 1, 2013, deletes or extends that date.

SEC. 16. Section 14167.41 of the Welfare and Institutions Code is amended to read:

14167.41. (a) Effective ~~January~~ July 1, 2011, there shall be imposed, pursuant to subdivision (b), a quality assurance fee in a manner necessary to obtain federal Medicaid matching funds that shall be due and payable to the department by each general acute care hospital at the rate of twenty-seven dollars and twenty-five cents ($27.25) per managed care day, as defined by the department, for the purpose of making Medi-Cal payments to hospitals.

(b) The quality assurance fee required by this article shall be imposed pursuant to the authority of a subsequent statute enacted to take effect on or after ~~January~~ July 1, 2011, that also does both of the following:

(1) Establishes how the revenue from the quality assurance fee on managed care days required by this article is apportioned among hospitals.

(2) Imposes a quality assurance fee for all other applicable hospital days.

(c) The subsequent statute described in subdivision (b) shall provide for a supplemental payment for Medi-Cal managed care inpatient days that shall not be less than the supplemental per diem rate for Medi-Cal managed care inpatient days set forth in Article 5.21 (commencing with Section 14167.1).

(d) This article shall be implemented only if, and to the extent that, all necessary federal approvals have been obtained.

(e) This article shall be implemented only if, and to the extent that, no increased cost to the General Fund results from implementation of this article.

SEC. 17. (a) For the purposes of this Section, the following terms have the following meanings:

(1) "Extension period" means the period of time starting January 1, 2011, and continuing through and including June 30, 2011, which is the additional six-month period this act extends the operation of Articles 5.21 (commencing with Section 14167.1) and 5.22 (commencing with Section 14167.31) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(2) "Original implementation period" means the period of time starting on the implementation date, as defined by Section 14167.1 of the Welfare and Institutions Code, and continuing through and including December 31, 2010.

(b) If it is determined that additional federal approvals must be secured for the extension period, the department shall seek those federal approvals as expeditiously as possible.

(c) To the extent that all necessary federal approvals have already been secured to implement Articles 5.21 (commencing with Section 14167.1) and 5.22 (commencing with Section 14167.31) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, for the original implementation period, failure to secure necessary federal approvals for the extension period shall not invalidate the operation of those articles for the original implementation period.

SEC. 18. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this act by means of provider bulletins, policy letters, or similar instructions, without taking further regulatory action.

SEC. 19. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary for implementation of the Budget Act of 2011, it is necessary that this act take effect immediately.

- 0 -

An act to amend Sections 9562, 9565, and 9567 of, to amend and renumber Section 14132.99 of, and to repeal Section 9568 of, the Welfare and Institutions Code, relating to seniors, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Medi-Cal: premium payments.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. The Medi-Cal program is partially governed and funded by federal Medicaid provisions.

Existing law, operative 30 days after the date that the increase in the state's federal medical assistance percentage (FMAP) pursuant to the federal American Recovery and Reinvestment Act of 2009 (ARRA) is no longer available, requires, no longer than 90 days after this operative date, each individual to pay a monthly premium that is equal to 5% of his or her individual or spousal countable income, as described, except that the premium cannot fall below or exceed a specified minimum and maximum premium payment, as provided. Existing law requires these provisions to be implemented only to the extent that federal financial participation is available, and

only to the extent that the department seeks and obtains approval of all necessary state plan amendments.

This bill would, instead, make these provisions operative 30 days after the execution of a declaration by the Director of Health Care Services that states that implementation of these provisions will not jeopardize the state's ability to receive certain federal funds. This bill would require, if the director determines that this statement in the declaration may no longer be accurate, the director to give notice to the Joint Legislative Budget Committee and the Department of Finance. This bill would also make these provisions inoperative on the date of a declaration by the director, if the director, in consultation with the Department of Finance, determines this to be necessary in order to receive certain federal funds. This bill would require the director to post a declaration on the department's Internet Web site, and to provide the declaration to specified persons.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 9562 of the Welfare and Institutions Code is amended to read:

9562. (a) This chapter shall be administered by the department, under the authority of an approved interagency agreement with the State Department of Health Care Services, the single state medicaid agency.

(b) To the extent permitted by federal law, each department within the California Health and ~~Welfare~~ Human Services Agency including departments designated as single state agencies for the programs described in Section 9561, shall waive regulations and general policies and make resources available which are necessary for the administration of this chapter, upon request of the agency.

SEC. 2. Section 9565 of the Welfare and Institutions Code is amended to read:

9565. The department shall do all of the following:

(a) Enter into agreements and negotiated contracts with any nonprofit organization or governmental entity to operate the local sites, consistent with the criteria adopted pursuant to Section 9563. In letting these contracts, the department shall not anticipate future appropriations.

(b) Make grants to local sites from available funds.

(c) Monitor local sites.

(d) Cause the service sites to be evaluated in accordance with the established criteria.

(e) Seek and utilize any available federal, state, or private funds that may be available for carrying out the purposes of this chapter.

(f) Notwithstanding any other provision of law, local sites established pursuant to this chapter may contract with the Director of Health Care Services as Medi-Cal programs pursuant to Chapter 8 (commencing with Section 14200) of Part 3 of Division 9. Contracts with the local sites shall be deemed to be for the purposes specified in Section 14494, and may utilize funds appropriated from the Health Care Deposit Fund pursuant to Section 14157.

(g) Assist in coordinating local site programs with local governmental programs and services for older individuals.

SEC. 3. Section 9567 of the Welfare and Institutions Code is amended to read:

9567. (a) This chapter shall remain ~~in effect~~ operative so long as a waiver pursuant to Section 1396n(c) of Title 42 of the United States Code has been granted by the federal Department of Health and Human Services to the State Department of Health Care Services to provide services under this chapter, and the Legislature has made an appropriation for this purpose.

(b) If funding for purposes of this chapter is not appropriated by the Legislature, the State Department of Health Care Services shall terminate the waiver described in subdivision (a). Upon termination of the waiver, the following persons shall receive services as facility residents under the waiver described in Section 14132.991:

(1) Participants under the waiver whose eligibility for Medi-Cal services was established under the waiver through the institutional deeming process.

(2) Persons who are 65 years of age or older on or after the date the waiver is terminated, satisfy the criteria for nursing facility A or B level of care, and are eligible for Medi-Cal services through the institutional deeming process.

(c) (1) The amendments made to this section by the addition of subdivision (b) by the act that added this subdivision, shall not become operative unless the Director of Health Care Services receives written confirmation from the federal Centers for Medicare and Medicaid Services (CMS) that the implementation of those provisions will not jeopardize the state's receipt of federal financial participation nor cause the state to be ineligible for an increase in its federal medical assistance percentage (FMAP) under the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) or the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). Upon receipt of this confirmation, the director shall execute a declaration stating that the confirmation has been received and the date of its receipt. The director shall retain the original declaration, post the declaration on the department's Internet Web site, and provide a copy, within five working days of its execution, to the Director of Finance, the Chair of the Senate Committee on Health, the Chair of the Assembly Committee on Health, and the Chair of the Joint Legislative Budget Committee. The addition of subdivision (b) by the act that added this subdivision shall become operative 30 days after the date that the Director of Health Care Services receives the written confirmation from CMS.

(2) If at any time after subdivision (b) as added by the act that added this subdivision becomes operative, the Director of Health Care Services determines that implementation of these provisions may jeopardize the state's receipt of federal financial assistance or cause the state to be ineligible for an increase in its FMAP under the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) or the Patient

Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), the director may execute a declaration stating this, and subdivision (b), as added by the act that added this subdivision, shall become inoperative on the date the declaration is executed, in which case the director shall exercise his or her authority under paragraph (3). The director shall retain the original declaration, post the declaration on the department's Internet Web site, and provide a copy, within five working days of its execution, to the Director of Finance, the Chair of the Senate Committee on Health, the Chair of the Assembly Committee on Health, and the Chair of the Joint Legislative Budget Committee.

(3) The Director of Health Care Services may take any actions the director deems necessary to best effectuate the goals of this chapter and to enable the state to receive federal financial participation and increases in its FMAP under the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) or the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

SEC. 4. Section 9568 of the Welfare and Institutions Code is repealed.

~~9568. The department shall explore options for, and obtain necessary legislative and governmental agency approvals to expand, the Multipurpose Senior Services Program. The department shall attempt to obtain the necessary federal approval to expand access to case management services into every planning and service area in the state and to improve the delivery of case management services.~~

SEC. 5. Section 14132.99 of the Welfare and Institutions Code, as added by Section 3 of Chapter 551 of the Statutes of 2005, is amended and renumbered to read:

~~14132.99.~~

14132.991. (a) For the purposes of this section, "facility residents" means individuals who are currently residing in a nursing facility and whose care is paid for by Medi-Cal either with or without a share of cost. The term "facility residents" also includes individuals who are hospitalized and who are or will be waiting for transfer to a nursing facility.

(b) An additional 500 slots beyond those currently authorized for ~~the home- and community-based Level A/B nursing facility waiver shall be added and 250 of these slots shall be reserved for residents residing in facilities and transitioning out of facilities~~ Nursing Facility/Acute Hospital waiver at nursing facility level A or B shall be added and 250 of these slots shall be reserved for facility residents.

(c) For those patients who are in acute care hospitals and who are pending placement in a nursing facility, the department shall expedite the processing of waiver applications in order to divert hospital discharges from nursing facilities into the community.

(d) The ~~nursing facility Level A/B waivers~~ Nursing Facility/Acute Hospital waiver shall be amended to add the following services:

(1) One-time community transition services as defined and allowed by the federal Centers for Medicare and Medicaid Services, including, but not limited to, security deposits that are required to obtain a lease on an apartment or home, essential furnishings, and moving expenses required to occupy and use a community domicile,

set-up fees, or deposits for utility or service access, including, but not limited to, telephone, electricity, and heating, and health and safety assurances, including, but not limited to, pest eradication, allergen control, or one-time cleaning prior to occupancy. These costs shall not exceed five thousand dollars ($5,000).

(2) Habilitation services, as defined in Section 1915(c)(5) of the federal Social Security Act (42 U.S.C. Sec. 1396n(c)(5)), and in attachment 3-d to the July 25, 2003, State Medicaid Directors Letter re Olmstead Update No. 3, to mean services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home- and community-based settings.

(e) When requesting the renewal of the waiver, the department shall consider expanding the number of waiver slots. Prior to submission of the waiver renewal request, the department shall notify the appropriate fiscal and policy committees of the Legislature of the number of waiver slots included in the waiver renewal request along with supportive data for those slots.

(f) The department shall implement this section only to the extent it can demonstrate fiscal neutrality within the overall department budget, and federal fiscal neutrality as required under the terms of the federal waiver, and only if the department has obtained the necessary approvals and receives federal financial participation from the federal Centers for Medicare and Medicaid Services. Contingent upon federal approval of the waiver expansion, implementation shall commence within six months of the department receiving authorization for the necessary resources to provide the services to additional waiver participants.

(g) The department's fiscal neutrality requirement, as described in subdivision (f), shall not apply to either of the following:

(1) The placement of a participant into the Nursing Facility/Acute Hospital waiver in a nursing facility level A or B waiver slot, if the participant was discharged from the Multipurpose Senior Services Program (MSSP) waiver due to termination of the MSSP waiver, and the participant's eligibility for Medi-Cal services was previously established through the institutional deeming process, pursuant to subdivision (b) of Section 9567.

(2) The placement of a person who is 65 years of age or older on or after the date the MSSP waiver is terminated satisfies the criteria for nursing facility A or B level of care, and is eligible for Medi-Cal services through the institutional deeming process, pursuant to subdivision (b) of Section 9567. A person described in this paragraph shall be placed into a level A or B Nursing Facility/Acute Hospital waiver slot otherwise reserved for a facility resident, as defined in subdivision (a). Upon placement of a person pursuant to this paragraph, the department may place an eligible person from the community waiting list into a vacant level A or B Nursing Facility/Acute Hospital waiver slot, to the extent that a slot is available for community placement.

(h) (1) The amendments made to this section by the addition of subdivision (g) by the act that added this subdivision shall not become operative unless the Director of Health Care Services receives written confirmation from the federal Centers for Medicare and Medicaid Services (CMS) that the implementation of those provisions will not jeopardize the state's receipt of federal financial participation nor cause the

state to be ineligible for an increase in its federal medical assistance percentage (FMAP) under the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) or the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). Upon receipt of this confirmation, the director shall execute a declaration stating that the confirmation has been received and the date of its receipt. The director shall retain the original declaration, post the declaration on the department's Internet Web site, and provide a copy, within five working days of its execution, to the Director of Finance, the Chair of the Senate Committee on Health, the Chair of the Assembly Committee on Health, and the Chair of the Joint Legislative Budget Committee. The addition of subdivision (g) by the act that added this subdivision shall become operative 30 days after the date that the Director of Health Care Services receives the written confirmation from CMS.

(2) If at any time after subdivision (g) as added by the act that added this subdivision becomes operative, the Director of Health Care Services determines that implementation of these provisions may jeopardize the state's receipt of federal financial assistance or cause the state to be ineligible for an increase in its FMAP under the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) or the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), the director may execute a declaration stating this, and subdivision (g), as added by the act that added this subdivision, shall become inoperative on the date the declaration is executed, in which case the director shall exercise his or her authority under paragraph (3). The

director shall retain the original declaration, post the declaration on the department's Internet Web site, and provide a copy, within five working days of its execution, to the Director of Finance, the Chair of the Senate Committee on Health, the Chair of the Assembly Committee on Health, and the Chair of the Joint Legislative Budget Committee.

(3) The Director of Health Care Services may take any actions the director deems necessary to best effectuate the goals of this section and to enable the state to receive federal financial participation and increases in its FMAP under the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) or the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

SEC. 6. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary for implementation of the Budget Act of 2011, it is necessary for this act to take effect immediately.

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LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Seniors: care: community settings.

Existing law, the Mello-Granlund Older Californians Act, establishes the Multipurpose Senior Services Program (MSSP) to provide specified services to frail elderly individuals 65 years of age and older who are certifiable for placement in a nursing facility. Existing law requires the California Department of Aging to administer the program in accordance with an interagency agreement with the State Department of Health Care Services. Existing law conditions operation of the MSSP on the granting of a specified federal waiver to the State Department of Health Care Services.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, and which provides health care services to qualified low-income recipients. The Medi-Cal program is partially governed and funded by federal Medicaid provisions.

Under existing law, the State Department of Health Care Services has obtained various waivers of Medicaid provisions generally aimed at enabling more Medi-Cal recipients to obtain the necessary services to reside in community settings. Existing law authorizes the department to seek an increase in the scope of these waivers, in order to enable additional nursing facility residents to transition into the community, but conditions implementation of these amended waivers upon obtaining federal financial participation and demonstration of fiscal neutrality within the overall department budget.

Existing law requires the California Department of Aging to explore options and seek approvals for expansion of the MSSP, as specified.

This bill would condition operation of the MSSP on both the federal waiver and an appropriation by the Legislature for that purpose. The bill would provide that if the Legislature does not make this appropriation, MSSP participants would be eligible to receive services under the existing Medi-Cal home and community-based services waiver, as prescribed. The bill would provide that the existing fiscal neutrality requirement would not be applicable to placement of Medi-Cal waiver participants who would otherwise have been participants in or eligible for the MSSP waiver. This bill would delete the requirement that the department explore options and seek approvals to expand the MSSP.

This bill would delay operation of its changes until the Director of Health Care Services receives written confirmation from the federal Centers for Medicare and Medicaid Services that its implementation would not jeopardize certain federal funding. The bill would authorize the director, by declaration, to cease implementation of its

provisions if the director determines that continued implementation would jeopardize the federal funding described in the bill. This bill would authorize the director to take any actions the director deems necessary to best effectuate the goals of the bill and to enable the state to receive related federal funding. This bill would also make related technical, nonsubstantive changes.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

An act to amend Section 14007.9 of the Welfare and Institutions Code, relating to Medi-Cal, and declaring the urgency thereof, to take effect immediately.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14007.9 of the Welfare and Institutions Code, as amended by Section 1 of Chapter 282 of the Statutes of 2009, is amended to read:

14007.9. (a) (1) The department shall adopt the option made available under Section 1902(a)(10)(A)(ii)(XIII) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIII)). In order to be eligible for benefits under this section, an individual shall be required to meet all of the following requirements:

(A) His or her net countable income is less than 250 percent of the federal poverty level for one person or, if the deeming of spousal income applies to the individual, his or her net countable income is less than 250 percent of the federal poverty level for two persons.

(B) He or she is disabled under Title II of the federal Social Security Act (42 U.S.C. Sec. 401 et seq.), Title XVI of the federal Social Security Act (42 U.S.C. Sec. 1381 et seq.), or Section 1902(v) of the federal Social Security Act (42 U.S.C. Sec. 1396a(v)). An individual shall be determined to be eligible under this section without regard to his or her ability to engage in, or actual engagement in, substantial gainful activity, as defined in Section 223(d)(4) of the federal Social Security Act (42 U.S.C. Sec. 423(d)(4)).

(C) Except as otherwise provided in this section, his or her net nonexempt resources, which shall be determined in accordance with the methodology used under Title XVI of the federal Social Security Act (42 U.S.C. Sec. 1381 et seq.), are not in excess of the limits provided for under those provisions.

(2) To the extent federal financial participation is available, an individual otherwise eligible under this section, but who is temporarily unemployed, may elect to remain on Medi-Cal under this section for up to 26 weeks, provided the individual continues to pay premiums during the temporary period of unemployment.

(b) (1) Countable income shall be determined under Section 1612 of the federal Social Security Act (42 U.S.C. Sec. 1382a), except that the individual's disability income, including all federal and state disability benefits and private disability insurance, shall be exempted. Resources excluded under Section 1613 of the federal Social Security Act (42 U.S.C. Sec. 1382b) shall be disregarded.

(2) Resources in the form of employer or individual retirement arrangements authorized under the Internal Revenue Code shall be exempted as authorized by Section 1902(r) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)).

(3) (A) For the purposes of calculating countable income under this section, an income exemption shall be applied as necessary to adjust the income standard so that it is the same as the income standard that was in place on May 1, 2009.

(B) This additional income exemption shall cease to be implemented when the SSI/SSP program payment levels increase beyond those in effect on May 1, 2009.

(C) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this paragraph by means of an all-county letter or similar instruction without taking regulatory action.

(4) Retained earned income of an eligible individual who is receiving health care benefits under this section shall be considered an exempt resource when held in a

separately identifiable account and not commingled with other resources, as authorized by Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)).

(5) Social security disability income that converts to social security retirement income upon the retirement of an individual, including any increases in the amount of that income, shall be exempt. The department shall submit a state plan amendment for this specific exemption, and the exemption shall be implemented only if, and to the extent that, the state plan amendment is approved.

(c) All resources exempted pursuant to paragraph (2) of subdivision (b) for an individual who is receiving health care benefits under this section shall continue to be exempt under any other Medi-Cal program that is subject to Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)) under which the beneficiary later becomes eligible for medical assistance where that eligibility is based on age, blindness, or disability. The department shall submit a state plan amendment for this specific exemption, and the exemption shall be implemented only if, and to the extent that, the state plan amendment is approved.

(d) After an individual is determined eligible for Medi-Cal benefits under this section, the individual's countable income, as determined under Section 1612 of the federal Social Security Act (42 U.S.C. Sec. 1382a), shall be used to determine the amount of the individual's required premium payment, as described in subdivision (f). Disability income and converted retirement income made exempt under paragraphs (1) and (5), respectively, of subdivision (b) for eligibility purposes shall be considered countable income for purposes of determining the amount of the required premium payment.

(e) Medi-Cal benefits provided under this chapter pursuant to this section shall be available in the same amount, duration, and scope as those benefits are available for persons who are eligible for Medi-Cal benefits as categorically needy persons and as specified in Section 14007.5.

(f) (1) Individuals eligible for Medi-Cal benefits under this section shall be subject to the payment of premiums determined under this subdivision. Each individual shall pay a monthly premium that is equal to 5 percent of his or her individual countable income, as described in subdivision (d), or if the deeming of spousal income of an ineligible spouse applies, a monthly premium that is equal to 5 percent of the total countable income of both spouses, except that the minimum premium payment per eligible individual shall be twenty dollars ($20) per month, and the maximum premium payment per eligible individual shall be two hundred fifty dollars ($250) per month.

(2) The amendments made to this subdivision by ~~the act that added subdivision (k)~~ Chapter 282 of the Statutes of 2009 shall be implemented no later than 90 days after the operative date specified in ~~that subdivision~~ paragraph (2) of subdivision (k).

(g) In order to implement the collection of premiums under this section, the department may develop and execute a contract with a public or private entity to collect premiums, or may amend any existing or future premium-collection contract that it has executed. Notwithstanding any other provision of law, any contract developed and executed or amended pursuant to this subdivision is exempt from the approval of the Director of General Services and from the Public Contract Code.

(h) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the

department shall implement, without taking any regulatory action, this section by means of an all-county letter or similar instruction. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(i) Notwithstanding any other law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation is available pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and only to the extent that the department seeks and obtains approval of all necessary Medicaid state plan amendments.

(j) If any provision of this section, or its application, is held invalid by a final judicial determination, it shall cease to be implemented. A determination of invalidity shall not affect other provisions or applications of this section that can be given effect without the implementation of the invalid provision or application.

(k) ~~The~~ (1) Except as provided in paragraph (2), the amendments made to this section by ~~the act that added this subdivision~~ Chapter 282 of the Statutes of 2009 shall not become operative until 30 days after the date that the increase in the state's federal medical assistance percentage (FMAP) pursuant to the federal American Recovery and Reinvestment Act of 2009 ~~(P.L.~~ (Public Law 111-5) is no longer available under that act or any extension of that act.

(2) The amendments made to this section by Chapter 282 of the Statutes of 2009 contained in subdivisions (d) and (f) shall not become operative until 30 days after the date that the director executes a declaration stating that the implementation of subdivisions (d) and (f) will not jeopardize the state's ability to receive federal financial

participation, any increase in the FMAP available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, determines would be advantageous to the state.

(3) If at any time the director determines that the statement in the declaration executed pursuant to paragraph (2) may no longer be accurate, the director shall give notice to the Joint Legislative Budget Committee and to the Department of Finance. After ~~giving~~ this notice is given the amendments made to this section by Chapter 282 of the Statutes of 2009 contained in subdivisions (d) and (f) shall become inoperative on the date that the director executes a declaration stating that the department has determined, in consultation with the Department of Finance, that it is necessary to cease to implement subdivisions (d) and (f) in order to receive federal financial participation, any increase in the FMAP available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, has determined would be advantageous to the state, in which case, subdivision (d) of this section, as ~~amended by~~ stated in Section 32 of Chapter 5 of the 2009 4th Extraordinary Session, shall be operative.

(4) The director shall post a declaration made pursuant to paragraph (2) or (3) on the department's Internet Web site and the director shall send the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(l) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement subdivision (k) by means of all-county letters or similar instruction, without taking regulatory action.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to ensure that the state and counties are able to continue to receive increased federal financial participation and to ensure the continued receipt of federal financial participation, it is necessary that this act take effect immediately.

- 0 -

An act to amend Section 14132 of the Welfare and Institutions Code, relating to Medi-Cal, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____.

General Subject: Medi-Cal: nonlegend drug benefits.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. Under existing law, Medi-Cal benefits include coverage of prescribed drugs subject to the Medi-Cal List of Contract Drugs and utilization controls. Existing law provides that nonlegend acetaminophen-containing products, with the exception of children's Tylenol, selected by the department are not covered benefits.

This bill would, instead, provide that nonlegend acetaminophen-containing products, with the exception of children's acetaminophen-containing products, selected by the department are not covered benefits.

This bill would also provide that nonlegend cough and cold products selected by the department are not covered benefits, as specified.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14132 of the Welfare and Institutions Code is amended to read:

14132. The following is the schedule of benefits under this chapter:

(a) Outpatient services are covered as follows:

Physician, hospital or clinic outpatient, surgical center, respiratory care, optometric, chiropractic, psychology, podiatric, occupational therapy, physical therapy, speech therapy, audiology, acupuncture to the extent federal matching funds are provided for acupuncture, and services of persons rendering treatment by prayer or healing by spiritual means in the practice of any church or religious denomination insofar as these can be encompassed by federal participation under an approved plan, subject to utilization controls.

(b) Inpatient hospital services, including, but not limited to, physician and podiatric services, physical therapy and occupational therapy, are covered subject to utilization controls.

(c) Nursing facility services, subacute care services, and services provided by any category of intermediate care facility for the developmentally disabled, including podiatry, physician, nurse practitioner services, and prescribed drugs, as described in subdivision (d), are covered subject to utilization controls. Respiratory care, physical therapy, occupational therapy, speech therapy, and audiology services for patients in nursing facilities and any category of intermediate care facility for the developmentally disabled are covered subject to utilization controls.

(d) (1) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.

(2) Purchase of drugs used to treat erectile dysfunction or any off-label uses of those drugs are covered only to the extent that federal financial participation is available.

(3) (A) To the extent required by federal law, the purchase of outpatient prescribed drugs, for which the prescription is executed by a prescriber in written, nonelectronic form on or after April 1, 2008, is covered only when executed on a tamper resistant prescription form. The implementation of this paragraph shall conform to the guidance issued by the federal Centers of Medicare and Medicaid Services but shall not conflict with state statutes on the characteristics of tamper resistant prescriptions for controlled substances, including Section 11162.1 of the Health and Safety Code. The department shall provide providers and beneficiaries with as much flexibility in implementing these rules as allowed by the federal government. The department shall notify and consult with appropriate stakeholders in implementing, interpreting, or making specific this paragraph.

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instructions without taking regulatory action.

(4) (A) ~~Nonlegend acetaminophen-containing products, with the exception of children's Tylenol, selected by the department are not covered benefits.~~ (i) For the purposes of this paragraph, nonlegend has the same meaning as defined in subdivision (a) of Section 14105.45.

(ii) Nonlegend acetaminophen-containing products, with the exception of children's acetaminophen-containing products, selected by the department are not covered benefits.

(iii) Nonlegend cough and cold products selected by the department are not covered benefits. This clause shall be implemented on the first day of the first calendar month following 90 days after the effective date of the act that added this clause.

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instruction without taking regulatory action.

(e) Outpatient dialysis services and home hemodialysis services, including physician services, medical supplies, drugs and equipment required for dialysis, are covered, subject to utilization controls.

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetist services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and X-ray services are covered, subject to utilization controls. Nothing in this subdivision shall be construed to require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable X-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance

of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses which are lost or destroyed due to circumstances beyond the beneficiary's control. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions that preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children Services Program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.

(3) Paragraph (2) shall become inoperative July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.

(j) Home health care services are covered, subject to utilization controls.

(k) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated, is covered subject to utilization controls. When there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

Therapeutic shoes and inserts are covered when provided to beneficiaries with a diagnosis of diabetes, subject to utilization controls, to the extent that federal financial participation is available.

(*l*) Hearing aids are covered, subject to utilization controls. Utilization controls shall allow replacement of hearing aids necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable

medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control. The utilization controls shall allow authorization of durable medical equipment needed to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian, subject to the availability of federal financial participation. The department shall adopt emergency regulations to define and establish criteria for assistive durable medical equipment in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(n) Family planning services are covered, subject to utilization controls.

(o) Inpatient intensive rehabilitation hospital services, including respiratory rehabilitation services, in a general acute care hospital are covered, subject to utilization controls, when either of the following criteria are met:

(1) A patient with a permanent disability or severe impairment requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to develop function beyond the limited amount that would occur in the normal course of recovery.

(2) A patient with a chronic or progressive disease requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to maintain the patient's present functional level as long as possible.

(p) (1) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).

(2) Commencing 30 days after the effective date of the act that added this paragraph, and notwithstanding the number of days previously approved through a treatment authorization request, adult day health care is covered for a maximum of three days per week.

(3) As provided in accordance with paragraph (4), adult day health care is covered for a maximum of five days per week.

(4) As of the date that the director makes the declaration described in subdivision (g) of Section 14525.1, paragraph (2) shall become inoperative and paragraph (3) shall become operative.

(q) (1) Application of fluoride, or other appropriate fluoride treatment as defined by the department, other prophylaxis treatment for children 17 years of age and under, are covered.

(2) All dental hygiene services provided by a registered dental hygienist in alternative practice pursuant to Sections 1768 and 1770 of the Business and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist in alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of Section 1482 of the article.

(2) All providers enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.

(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

(s) In-home medical care services are covered when medically appropriate and subject to utilization controls, for beneficiaries who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to patients placed in shared or congregate living arrangements, if a home setting is not medically appropriate or available to the beneficiary. As used in this section, "in-home medical care service" includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

As used in this subdivision, in-home medical care services, include, but are not limited to:

(1) Level of care and cost of care evaluations.

(2) Expenses, directly attributable to home care activities, for materials.

(3) Physician fees for home visits.

(4) Expenses directly attributable to home care activities for shelter and modification to shelter.

(5) Expenses directly attributable to additional costs of special diets, including tube feeding.

(6) Medically related personal services.

(7) Home nursing education.

(8) Emergency maintenance repair.

(9) Home health agency personnel benefits which permit coverage of care during periods when regular personnel are on vacation or using sick leave.

(10) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.

(11) Emergency and nonemergency medical transportation.

(12) Medical supplies.

(13) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.

(14) Utility use directly attributable to the requirements of home care activities which are in addition to normal utility use.

(15) Special drugs and medications.

(16) Home health agency supervision of visiting staff which is medically necessary, but not included in the home health agency rate.

(17) Therapy services.

(18) Household appliances and household utensil costs directly attributable to home care activities.

(19) Modification of medical equipment for home use.

(20) Training and orientation for use of life-support systems, including, but not limited to, support of respiratory functions.

(21) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.

Beneficiaries receiving in-home medical care services are entitled to the full range of services within the Medi-Cal scope of benefits as defined by this section, subject to medical necessity and applicable utilization control. Services provided pursuant to this subdivision, which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with a home- and community-based services waiver.

(t) Home- and community-based services approved by the United States Department of Health and Human Services may be covered to the extent that federal financial participation is available for those services under waivers granted in accordance with Section 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.

(u) Comprehensive perinatal services, as provided through an agreement with a health care provider designated in Section 14134.5 and meeting the standards developed by the department pursuant to Section 14134.5, subject to utilization controls.

The department shall seek any federal waivers necessary to implement the provisions of this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained

or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for the other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.

(v) Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(w) Hospice service which is Medicare-certified hospice service is covered, subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred.

(x) When a claim for treatment provided to a beneficiary includes both services which are authorized and reimbursable under this chapter, and services which are not reimbursable under this chapter, that portion of the claim for the treatment and services authorized and reimbursable under this chapter shall be payable.

(y) Home- and community-based services approved by the United States Department of Health and Human Services for beneficiaries with a diagnosis of AIDS or ARC, who require intermediate care or a higher level of care.

Services provided pursuant to a waiver obtained from the Secretary of the United States Department of Health and Human Services pursuant to this subdivision, and which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with the waiver, and subject to the terms, conditions, and duration of the waiver. These services shall be provided to individual beneficiaries in accordance with

the client's needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.

The director may under this section contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to eligible beneficiaries. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions Code, and as an in-home medical service as outlined in subdivision (s).

(aa) (1) There is hereby established in the department, a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Program.

(2) The department shall seek a waiver in accordance with Section 1315 of Title 42 of the United States Code, or a state plan amendment adopted in accordance with Section 1396a(a)(10)(A)(ii)(XXI)(ii)(2) of Title 42 of the United States Code, which was added to Section 1396a of Title 42 of the United States Code by Section 2303(a)(2) of the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), for a program to provide comprehensive clinical family planning services as described in paragraph (8). Under the waiver, the program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and

subject to the terms, conditions, and duration of the waiver. Under the state plan amendment, which shall replace the waiver and shall be known as the Family PACT successor state plan amendment, the program shall be operated only in accordance with this subdivision and the statutes and regulations in paragraph (4). The state shall use the standards and processes imposed by the state on January 1, 2007, including the application of an eligibility discount factor to the extent required by the federal Centers for Medicare and Medicaid Services, for purposes of determining eligibility as permitted under Section 1396a(a)(10)(A)(ii)(XXI)(ii)(2) of Title 42 of the United States Code. To the extent that federal financial participation is available, the program shall continue to conduct education, outreach, enrollment, service delivery, and evaluation services as specified under the waiver. The services shall be provided under the program only if the waiver and, when applicable, the successor state plan amendment are approved by the federal Centers for Medicare and Medicaid Services and only to the extent that federal financial participation is available for the services. Nothing in this section shall prohibit the department from seeking the Family PACT successor state plan amendment during the operation of the waiver.

(3) Solely for the purposes of the waiver or Family PACT successor state plan amendment and notwithstanding any other provision of law, the collection and use of an individual's social security number shall be necessary only to the extent required by federal law.

(4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005, and 24013, and any regulations adopted under these statutes shall apply to the program provided for under this subdivision. No other provision of law under the Medi-Cal program or the

State-Only Family Planning Program shall apply to the program provided for under this subdivision.

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, without taking regulatory action, the provisions of the waiver after its approval by the federal Health Care Financing Administration and the provisions of this section by means of an all-county letter or similar instruction to providers. Thereafter, the department shall adopt regulations to implement this section and the approved waiver in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of the act adding this subdivision, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(6) In the event that the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) or the Family PACT successor state plan amendment is no longer cost effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the

Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no share of cost, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a share of cost or if they are otherwise eligible under Section 24003.

(8) For purposes of this subdivision, "comprehensive clinical family planning services" means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family planning services shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

(B) All United States Department of Agriculture, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(C) Culturally and linguistically appropriate health education and counseling services, including informed consent, that include all of the following:

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

(x) Use of contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies.

(xi) Possible contraceptive consequences and followup.

(xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(D) A comprehensive health history, updated at the next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

(E) A complete physical examination on initial and subsequent periodic visits.

(F) Services, drugs, devices, and supplies deemed by the federal Centers for Medicare and Medicaid Services to be appropriate for inclusion in the program.

(9) In order to maximize the availability of federal financial participation under this subdivision, the director shall have the discretion to implement the Family PACT successor state plan amendment retroactively to July 1, 2010.

(ab) Purchase of prescribed enteral formulae is covered, subject to the Medi-Cal list of enteral formulae and utilization controls.

(ac) Diabetic testing supplies are covered when provided by a pharmacy, subject to utilization controls.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary for implementation of the Budget Act of 2011, it is necessary that this act take effect immediately.

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An act to amend and repeal Section 14134.1 of, and to amend, repeal, and add Section 14134 of, the Welfare and Institutions Code, relating to Medi-Cal, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, _____ .

General Subject: Medi-Cal: copayments.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Under existing law, Medi-Cal beneficiaries are required to make set copayments for specified services. Copayments for services, under existing law, do not reduce the reimbursement to the providers. Existing law prohibits a provider from denying services to an individual solely because the person is unable to pay the copayment.

This bill would, commencing as provided, revise the copayment rates, expand the services for which copayments are due, and require the department to reduce the amount of the payment to the provider by the amount of the copayment. The bill would

state that a provider has no obligation to provide services to a beneficiary who does not pay the copayment at the point of service.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14134 of the Welfare and Institutions Code is amended to read:

14134. Except for any prescription, refill, visit, service, device, or item for which the program's payment is ten dollars ($10) or less, in which case no copayment shall be required, a recipient of services under this chapter shall be required to make copayments not to exceed the maximum permitted under federal regulations or federal waivers as follows:

(a) Copayment of five dollars ($5) shall be made for nonemergency services received in an emergency room. For the purposes of this section, "nonemergency services" means any services not required for the alleviation of severe pain or the immediate diagnosis and treatment of severe medical conditions which, if not immediately diagnosed and treated, would lead to disability or death.

(b) Copayment of one dollar ($1) shall be made for each drug prescription or refill.

(c) Copayment of one dollar ($1) shall be made for each visit for services under subdivisions (a) and (h) of Section 14132.

(d) The copayment amounts set forth in subdivisions (a), (b), and (c) may be collected and retained or waived by the provider.

(e) The department shall not reduce the reimbursement otherwise due to providers as a result of the copayment. The copayment amounts shall be in addition to any reimbursement otherwise due the provider for services rendered under this program.

(f) This section does not apply to emergency services, family planning services, or to any services received by:

(1) Any child in AFDC-Foster Care, as defined in Section 11400.

(2) Any person who is an inpatient in a health facility, as defined in Section 1250 of the Health and Safety Code.

(3) Any person 18 years of age or under.

(4) Any woman receiving perinatal care.

(g) Subdivision (b) does not apply to any person 65 years of age or over.

(h) A provider of service shall not deny care or services to an individual solely because of that person's inability to copay under this section. An individual shall, however, remain liable to the provider for any copayment amount owed.

(i) The department shall seek any federal waivers necessary to implement this section. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented, but provisions for which waivers are either obtained or found to be unnecessary shall be unaffected by the inability to obtain federal waivers for the other provisions.

(j) The director shall adopt any regulations necessary to implement this section as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The director shall transmit these emergency regulations directly to the Secretary of State for filing and the regulations shall become effective immediately upon filing. Upon completion

of the formal regulation adoption process and prior to the expiration of the 120 day duration period of emergency regulations, the director shall transmit directly to the Secretary of State for filing the adopted regulations, the rulemaking file, and the certification of compliance as required by subdivision (e) of Section 11346.1 of the Government Code.

(k) (1) This section shall become inoperative on the first day of the month following 120 days after the date federal approval is obtained for implementation of Section 14134, as added by Section 2 of the act that added this subdivision or October 1, 2011, whichever is later, and, as of January 1 of the following year, is repealed.

(2) Notwithstanding paragraph (1), copayments for services pursuant to subdivision (h) of Section 14132 as provided in subdivision (c) shall become inoperative on the first day of the month following 60 days after federal approval is obtained for implementation of Section 14134, as added by Section 2 of the act that added this subdivision, or on May 1, 2011, whichever is later.

SEC. 2. Section 14134 is added to the Welfare and Institutions Code, to read:

14134. (a) In order to implement changes in the level of funding for health care services, a Medi-Cal beneficiary shall be required to make copayments as described in this section. These copayments represent a contribution toward the rate of payment made to providers of Medi-Cal services and shall be as follows:

(1) Copayment of up to fifty dollars ($50) shall be made for nonemergency services received in an emergency room. For the purposes of this section, "nonemergency services" means services not required for the alleviation of severe pain

or the immediate diagnosis and treatment of unforeseen medical conditions that, if not immediately diagnosed and treated, would lead to disability or death.

(2) Copayment of up to fifty dollars ($50) shall be made for emergency services received in an emergency room. For purposes of this section, "emergency services" means services required for the alleviation of severe pain or the immediate diagnosis and treatment of unforeseen medical conditions that, if not immediately diagnosed and treated, would lead to disability or death.

(3) Copayment of up to one hundred dollars ($100) shall be made for each hospital inpatient day, up to a maximum of two hundred dollars ($200) per admission.

(4) Copayment of up to three dollars ($3) shall be made for each preferred drug prescription or refill. A copayment of up to five dollars ($5) shall be made for each nonpreferred drug prescription or refill. Except as provided in subdivision (e), "preferred drug" shall have the same meaning as in Section 1916A of the Social Security Act (42 U.S.C. Sec. 13960-1).

(5) Copayment of up to five dollars ($5) shall be made for each visit for services under subdivision (a) of Section 14132 and for dental services received on an outpatient basis provided as a medical benefit pursuant to this chapter or Chapter 8 (commencing with Section 14200), as applicable.

(b) The copayments established pursuant to subdivision (a) shall be set by the department, at the maximum amount provided for in the applicable paragraph, except that each copayment amount shall not exceed the maximum amount allowable pursuant to the state plan amendments or other federal approvals.

(c) The copayment amounts set forth in subdivision (a) may be collected and retained or waived by the provider. The department shall deduct the amount of the copayment from the payment the department makes to the provider whether retained, waived, or not collected by the provider.

(d) Notwithstanding any other provision of law, and only to the extent allowed pursuant to federal law, a provider of service has no obligation to provide services to a Medi-Cal beneficiary who does not, at the point of service, pay the copayment assessed pursuant to this section. If the provider provides services without collecting the copayment, and has not waived the copayment, the provider may hold the beneficiary liable for the copayment amount owed.

(e) (1) Notwithstanding any other provision of law, except as described in paragraph (2), this section shall apply to Medi-Cal beneficiaries enrolled in a health plan contracting with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), Article 2.9 (commencing with Section 14088), and Article 2.91 (commencing with Section 14089) of this chapter, and Chapter 8 (commencing with Section 14200).

(2) For the purpose of paragraph (4) of subdivision (a), copayments assessed against a beneficiary who receives Medi-Cal services through a health plan described in paragraph (1) shall be based on the plan's designation of a drug as preferred or nonpreferred.

(3) To the extent provided by federal law, capitation payments shall be calculated as if copayments described in this section were collected.

(f) This section shall be implemented only to the extent that federal financial participation is available. The department shall seek and obtain any federal waivers or state plan amendments necessary to implement this section. The provisions for which appropriate federal waivers or state plan amendments cannot be obtained shall not be implemented, but provisions for which waivers or state plan amendments are either obtained or found to be unnecessary shall be unaffected by the inability to obtain federal waivers or state plan amendments for the other provisions.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, all-plan letters, provider bulletins, or similar instructions, without taking further regulatory actions.

(h) (1) This section shall become operative on the first day of the month following 120 days after federal approval is obtained for implementation of this section, or October 1, 2011, whichever is later.

(2) Notwithstanding paragraph (1), copayments for dental services pursuant to paragraph (5) of subdivision (a) shall become operative on the first day of the month following 60 days after federal approval is obtained for implementation of this section, or on May 1, 2011, whichever is later.

(3) Upon implementation of this section, as provided for in paragraphs (1) and (2), the director shall execute a declaration that implementation has commenced and the date upon which the commencement took place and shall post the declaration on the department's Internet Web site and provide a copy of the declaration to the chair

of the Joint Legislative Budget Committee, the Office of the Legislative Counsel, and the Secretary of State.

SEC. 3. Section 14134.1 of the Welfare and Institutions Code is amended to read:

14134.1. (a) Except as provided in subdivision ~~(b)~~ (d) of Section 14134, no provider under this chapter may deny care or services to an individual eligible for ~~such~~ care or services under this chapter ~~on account~~ because of the individual's inability to pay a copayment, as defined in Section 14134. The requirements of this section shall not extinguish the liability of the individual to whom the care or services were furnished for payment of the copayment.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, provider bulletins, or similar instructions, without taking further regulatory action.

(c) This section shall become inoperative on the first day of the month following 120 days after the date federal approval is obtained for implementation of Section 14134, as added by Section 2 of the act that added this subdivision or October 1, 2011, whichever is later, and, as of January 1 of the following year, is repealed.

SEC. 4. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary for implementation of the Budget Act of 2011 and changes to the Budget Act of 2010, it is necessary that this act take effect immediately.

- 0 -

LEGISLATIVE AGENDA ITEM DETAIL SHEET

Bill NUMBER/ISSUE: Individual Transition Plan

BILL SUMMARY: Amend the Developmental Disabilities Assistance and Bill of Rights Act (DD Act), Individual with Disabilities Act (IDEA) and the Rehabilitation Act (Rehab Act) to provide assistance to States for development and implementation of an Individual Transition Plan (ITP) for each person with significant disabilities who is transitioning from the secondary school system into adulthood, and for other purposes.

BACKGROUND: The draft legislation has been developed by The Collaboration to Promote Self-Determination (CPSD) which is an informal network of approximately 12 national organizations, including the National Fragile X Foundation, National Down Syndrome Society, and the Autism Society of America and is planned to be submitted to the House of Representatives by Congressman Gregg Harper (R-Miss) for consideration. The general tenet of the legislation is that state agencies that receive assistance under, DD Act, IDEA and Rehab Act shall develop, and assist in the implementation of, an ITP by providing transition services (TSP) to each individual with significant disability who is making the transition from the secondary school system into adulthood.

1- DD Act

The purpose of this proposal is to: (1) create a diverse and holistic system aimed at successful transitioning of youth with significant disabilities into adulthood; (2) enhance focus on equal opportunity, self determination informed choice, and outcome directed that leads to integrated employment and economic self sufficiency; (3) promote Innovative strategies to foster academic, professional and social inclusion, and Individual assurances to long term supports and full integration into the community; (4) clarify specific services related to effective transition of youth with significant disabilities; and (5) eliminate barriers through multiple stakeholders' collaboration.

2- IDEA

The purpose of this proposal is the same as DD Act.

3- Rehab Act

The purpose of this proposal is to amend the Rehab Act to authorize grants for the transition of youths with disabilities into adulthood, and for other purposes. An entity that receives a grant shall use the fund to carry out the following activities for youths with significant disabilities:

- development of innovative and effective person centered processes to assist the person to attain employment and prevailing wages and other opportunities;

- development of objectives and activities based upon expectations in the following areas:
  - ► Academic and school based experiences including access to general education curriculum;
  - ► Work and career readiness;
  - ► Self- determination and leadership;
  - ► Comprehensive community connections;
  - ► Life-long learning; and
  - ► Family involvement and engagement.

- development of appropriate curricula and the employment of professionals with expertise to provide training to school personnel including but not limited to transition coordinators;

- provision of assistance to youths with significant disabilities and their families with respect to determination of appropriate services under Federal and State programs including employment outcome, benefits planning and management, Individualized economic advancement strategies, etc; and

- sections on Prohibited Activities, Employment Outcome and Evaluation as well as Grant Appropriation.

ANALYSIS/DISCUSSION: These bills had been circulated in 2010 under Transition Toward Excellence, Achievement and Mobility Act (TEAM ACT) proposal sponsored by Congressman Gregg Harper (R-MS) and Congressman Patrick Kennedy (D-RI) but never moved legislatively.

Some early comments to the drafts include:

- "this should not be implemented without funding so that it does not become another unfunded title like Family Support and Direct Support. The DD Act is not a parking lot for unfunded titles."

- "it must be voluntary. Councils should not be mandated to do this. It must only be a competitive grant. States must have the option to apply."

- "funding this must be new dollars, not dollars taken from other parts of the act. In theory, if $50m is made available, that is about $1m per state. What is the likelihood of that happening, given the movement to reduce spending?"

- "I do not see how CT would apply. CT does not have a State Developmental Disability Authority. We have multiple such agencies. Is this really workable?"

California is working with various regional centers and the Department of Developmental Services (DDS) in relation to employment issues for individuals with significant disabilities and required measurable outcomes and achievements and may need extra resources and additional State legislative amendments that in current State fiscal environment it may not materialize.

COUNCIL STRATEGIC PLAN OBJECTIVE: Employment

RECOMMENDATION(S): Information only at this time.

ATTACHMENT(S): Three, unnumbered, draft measures.

PREPARED: Karim Alipourfard on February 2, 2011

[DISCUSSION DRAFT]

112TH CONGRESS
1ST SESSION

H. R. _____

To amend the Developmental Disabilities Assistance and Bill of Rights Act of 2000 to provide assistance to States for development and implementation of an individual transition plan for each individual with a developmental disability in the State who is making the transition from the secondary school system into adulthood, and for other purposes.

Mr. HARPER introduced the following bill; which was referred to the Committee on _____

A BILL

To amend the Developmental Disabilities Assistance and Bill of Rights Act of 2000 to provide assistance to States for development and implementation of an individual transition plan for each individual with a developmental disability in the State who is making the transition from the secondary school system into adulthood, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "_____ Act of 2011".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. INDIVIDUALIZED TRANSITION PLANS; TRANSITION PLANNING AND SERVICES ADMINISTRATIVE UNITS.

Title I of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) is amended by adding at the end the following:

"Subtitle F—Adult Transition System

"SEC. 171. DEFINITIONS.

"In this subtitle:

"(1) The term 'asset development' [*to be taken from provisions amending Rehab Act when final*]

"(2) The term 'individualized education program' has the meaning given such term in section 602 of the Individuals with Disabilities Education Act.

"(3) The term 'ITP' means an individual transition plan developed and implemented under section 173.

"(4) The term 'local educational agency' has the meaning given to such term in section 9101 of the Elementary and Secondary Education Act of 1965.

"(5) The term 'secondary school' has the meaning given to such term in section 9101 of the Elementary and Secondary Education Act of 1965.

"(6) The term 'State Developmental Disability Authority' means the primary State agency or subdivision with administrative, programmatic, and operational responsibility for the full range of services and supports furnished to individuals with developmental disabilities.

"(7) The term 'TPS administrative unit' refers to the transition planning and services administrative unit of a State established in accordance with section 174.

"(8) The term 'transition services' [*to be taken from provisions amending Rehab Act when final*]

"SEC. 172. STATE ASSISTANCE.

"For each fiscal year, the Secretary, acting through the Commissioner of the Administration on Developmental Disabilities, shall—

"(1) make grants on a competitive basis to States that agree to carry out the activities required of States under this subtitle; and

"(2) among the States receiving grants under paragraph (1), allocate payments pursuant to a formula that—

"(A) is established by the Secretary, acting through the Commissioner; and

"(B) takes into consideration an estimate of the number of individuals to be served under this subtitle in each State.

"SEC. 173. INDIVIDUALIZED TRANSITION PLANS.

"(a) IN GENERAL.—Each State that receives assistance under this subtitle shall develop, and assist in the implementation of, an individual transition plan for [*add?*: providing transition services to] [*Except for the reference to transition services under IDEA in subsection (b)(1), there is no reference to transition services in this section.*] each individual with a developmental disability in the State who is making the transition from the secondary school system into adulthood.

"(b) FORMULATION.—An ITP shall be—

"(1) coordinated with the individualized education program and [transition services] for the in-

dividual under the Individuals with Disabilities Education Act;

"(2) developed not later than 30 days after the date on which the individual graduates from or otherwise exits the State's secondary school system; and

"(3) applicable through the date on which the individual attains 26 years of age; and

"(4) developed during in-person meetings that—

"(A) are led by the TPS administrative unit of the State Developmental Disabilities Authority established under section 174; and

"(B) at a minimum, include the following stakeholders: the individual, the individual's family, a transition broker (as described in section 174), a representative of the State vocational rehabilitation agency, relevant service providers that are contracted by the State or chosen by the individual and the individual's family or guardian to provide transition services, the transition coordinator of the local educational agency (where available, during the first year the individual exits the secondary school system), assistive technology experts (as

appropriate), and representatives of the workforce development sector.

"(c) CONTENTS.—An ITP shall include strategies for the implementation of service models and practices with documented effectiveness that—

"(1) address and emphasize the 5 areas of postsecondary educational experiences, career preparation and work-based learning experiences, development and leadership, connecting activities, and family involvement and supports;

"(2) identify the needs of the individual in each of these 5 areas and articulate how the State and its agencies will meet those needs; and

"(3) will advance economic self-sufficiency with specific asset development goals and identify specific tools for advancing economic self-sufficiency, such as favorable tax benefits, work incentives, matched savings plans, education financing, and effective strategies to manage a budget, money, and credit.

"SEC. 174. TRANSITION PLANNING AND SERVICES ADMINISTRATIVE UNIT.

"(a) ESTABLISHMENT.—Each State that receives assistance under this subtitle shall establish and maintain a transition planning and services (TPS) administrative unit within the State Developmental Disability Authority.

"(b) RESPONSIBILITIES.—The primary focus of a TPS administrative unit shall be to assist individuals with a developmental disability in the State to make the transition from the secondary school system into adulthood. The responsibilities of the TPS administrative unit shall include the following:

"(1) INDIVIDUAL TRANSITION PLAN.—The TPS administrative unit shall have responsibility for developing and assisting in the implementation of ITPs.[*If a reference to transition services is put into section 173, the definition of transition services will be indirectly incorporated here and below through references to ITPs. Currently the term transition services is used in this section only in conjunction with describing the qualifications of transition brokers.*]

"(2) TRANSITION BROKERS.—

"(A) IN GENERAL.—The TPS administrative unit shall employ or otherwise secure the services of transition brokers.

"(B) ROLE.—A transition broker of the TPS administrative unit shall—

"(i) facilitate coordination among State agencies in the development of ITPs; and

"(ii) provide assistance to individuals with developmental disabilities, consistent with the individual's ITP, in navigating the complex system of supports and services available through Federal and State programs.

"(C) QUALIFICATIONS.—To be eligible to serve as a transition broker of the TPS administrative unit, an individual shall possess one or more of the following qualifications:

"(i) Expertise relating to individuals with developmental disabilities, benefits planning, the provision of [transition services], employment and job development, and negotiating among various State stakeholders.

"(ii) Experience with and knowledge of the generic workforce development sector, vocational rehabilitation, and job development.

"(iii) Knowledge and expertise in the use of tools to advance economic self-sufficiency, including favorable tax benefits, work incentives, matched savings plans, education financing, and effective strate-

gies to manage a budget, money, and credit.

"(iv) Knowledge about self-direction and person-centered planning processes.

"(D) ASSIGNMENT.—A transition broker of the TPS administrative unit shall be assigned to an individual upon—

"(i) the individual or the individual's family or guardian selecting the broker; and

"(ii) the State Developmental Disability Authority approving the selection.

"(3) SELF-ADVOCACY, SELF-DETERMINATION SKILLS, AND PEER MENTORING.—The TPS administrative unit shall offer strategies and training to individuals with developmental disabilities and their families regarding self-advocacy, self-determination skills, and peer mentoring to improve the ability of such individuals to advocate and negotiate on their own behalf.

"(4) EFFECTIVE INFORMATION AND RESOURCES.—The TPS administrative unit shall provide information to individuals with developmental disabilities and their families on Federal and State services, supports, and regulations, including with

respect to insurance and benefit programs, financial savings tools, and asset or income limits that affect eligibility for Federal and State means-tested services, supports, or programs. Such information shall be easily understood and updated on a quarterly basis each year.

"(c) FOSTERING MULTIAGENCY COLLABORATION.—The State Developmental Disability Authority of each State that receives assistance under this subtitle shall facilitate memoranda of understanding among key State agencies for the purpose of coordinating and improving the services and supports provided by such agencies to individuals with developmental disabilities during the transition into adulthood.

"SEC. 175. ANNUAL REPORT.

"Not later than the end of fiscal year 2012, and annually thereafter, the Secretary shall submit a report to the Congress containing an evaluation of the implementation and effectiveness of this subtitle, including an evaluation of—

"(1) progress made in [developing and] accomplishing the objectives of ITPs; and

"(2) with respect to individuals for whom an ITP is developed, their employment status, education status, income level, and current residence.

"SEC. 176. AUTHORIZATION OF APPROPRIATIONS.

"To carry out this subtitle, there is authorized to be appropriated $50,000,000 for fiscal year 2012 and each subsequent fiscal year.".

.....

(Original Signature of Member)

112TH CONGRESS
1ST SESSION

H. R. _____

To amend the Individuals with Disabilities Education Act to make improvements to the individualized education program under that Act and facilitate the transition of children with disabilities to adulthood, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mr. HARPER introduced the following bill; which was referred to the Committee on _____

A BILL

To amend the Individuals with Disabilities Education Act to make improvements to the individualized education program under that Act and facilitate the transition of children with disabilities to adulthood, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Transition toward Excellence, Achievement and Mobility through Education Act of 2011".

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds the following:

(1) Evidence-based research has conclusively documented that youth with significant disabilities who were educated in inclusive settings, were exposed to work experience and career exploration, and participated in a paid work experience while in school had better postsecondary outcomes and higher rates of sustainable employment.

(2) Higher rates of self-determination, in which individuals with significant disabilities and their families have direct control over the decision-making process in order to ensure an appropriate individualized transition strategy, lead to better outcomes.

(3) Regulations and processes allowing for flexibility in the blending and braiding of government funds to ensure seamless, collaborative strategies during the transition process lead to better outcomes for individuals with significant disabilities.

(4) Agency officials involved directly in the provision of supports and services during a youth's transition into adulthood and beyond must be provided additional training to become properly prepared to adequately address the individual employment preparation needs of students with significant disabilities.

(b) PURPOSES.—The purposes of this Act are the following:

(1) Create a holistic system across multiple partners focused on successful transition of youth with significant disabilities into adulthood.

(2) Create a systemic focus on achieving high expectations for all youth, through equality of opportunity, full participation through self-determination and informed choice, outcomes related to post-secondary options that lead to competitive integrated employment and economic self-sufficiency.

(3) Promote innovative strategies to foster academic, professional, and social inclusion, and the solidification of long-term supports and services required to ensure full integration into the community setting.

(4) Better define and coordinate specific services related to the effective transition of youth with significant disabilities.

(5) Eliminate barriers and promote incentives for multiple stakeholders to collaborate and improve transition opportunities for youth with significant disabilities.

SEC. 3. DEFINITIONS.

(a) TRANSITION SERVICES.—Section 602(34) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(34)) is amended—

(1) in subparagraph (A), by inserting "and customized employment" after "supported employment";

(2) in subparagraph (B), by striking "and" at the end;

(3) in subparagraph (C), by striking the period at the end and inserting a semicolon; and

(4) by adding at the end the following new subparagraphs:

"(D) includes training in self-advocacy and self-determination activities and the skills needed to participate in making informed choices to prepare and empower the child to advocate and negotiate on the child's own behalf; and

"(E) does not include facility-based employment or activity settings, such as sheltered workshops, day habilitation centers, mobile work crews, or enclave work settings.".

(b) OTHER DEFINITIONS.—Section 602 of the Individuals with Disabilities Education Act (20 U.S.C. 1401) is amended by adding at the end the following new paragraphs:

"(37) INFORMED CHOICE.—The term 'informed choice' means a choice-making process that includes the following elements:

"(A) The provision of adequate information to the child and the child's parents about the full range of options that are to be considered.

"(B) Sufficient resources (personnel as well as fiscal) to support the choice made by the child and the child's parents.

"(C) Willingness of any provider of services to accept the choice and the reasonable risks associated with the choice.

"(D) Information on the parameters of the choice and the relevant options being considered in the language and capabilities of the child in the choice-making process.

"(E) Acknowledgment by the child and all parties involved that the use of public-funds should be focused on choices that foster personal, social, and professional development in integrated settings and lead to outcomes of increased economic self-sufficiency and professional advancement.

"(38) INTEGRATED EMPLOYMENT.—The term 'integrated employment' means work compensated at the greater of minimum wage or prevailing wages with related employment benefits, occurring in a typical work setting where the employee with the disability interacts or has the opportunity to interact continuously with non-disabled co-workers, has an opportunity for advancement and mobility, and is preferably engaged in full-time employment.

"(39) SELF-DETERMINATION ACTIVITIES.—The term 'self-determination activities' has the meaning given the term in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002).

"(40) STATE INTELLECTUAL AND DEVELOPMENTAL DISABILITIES AGENCY.—The term 'State intellectual and developmental disabilities agency' means the State agency or subdivision with administrative, programmatic, and operational responsibility for the full range of services and supports furnished to individuals with intellectual and developmental disabilities".

SEC. 4. STATE-LEVEL ACTIVITIES.

Section 611(e)(2)(C) of the Individuals with Disabilities Education Act (20 U.S.C. 1411(e)(2)(C)) is amended—

(1) by redesignating clauses (vii) through (xi) as clauses (viii) through (xii), respectively; and

(2) by inserting after clause (vi) the following new clause:

"(vii) To enter into contracts with entities that have expertise in the provision of transition services specifically related to assisting children with disabilities in the accomplishment of the transition objectives outlined in the child's IEP to the extent such objectives relate to the provision of school-based preparatory activities, work-based learning experiences, career preparation, and job experiences in an integrated community setting, other than facility-based employment and activity settings, such as sheltered workshops, day habilitation centers, mobile work crews, and enclave work settings.".

SEC. 5. STATE ELIGIBILITY.

Section 612(a) of the Individuals with Disabilities Education Act (20 U.S.C. 1412(a)) is amended by adding at the end the following new paragraph:

"(26) PLAN RELATING TO TRANSITION SERVICES.—

"(A) IN GENERAL.—The State has established a plan to ensure that the State educational agency coordinates efforts among the various State agencies involved in the successful transition of youth with disabilities into adulthood, including the States agencies described in subparagraph (B), and to align practices and direct resources toward the effective provision of transition services to address the needs of children with disabilities, including involvement and progress in the general curriculum in the least restrictive environment, academic and school-based preparatory experiences, work and career readiness, youth development and leadership, comprehensive community connections, and family involvement and engagement.

"(B) STATE AGENCIES DESCRIBED.—The State agencies referred to in subparagraph (A) are—

"(i) the State intellectual and developmental disabilities agency;

"(ii) the State vocational rehabilitation agency;

"(iii) the agency responsible for the State medicaid program under title XIX of the Social Security Act; and

"(iv) the State department of labor or workforce investment board.".

SEC. 6. INDIVIDUALIZED EDUCATION PROGRAMS.

(a) EVALUATIONS BEFORE CHANGE IN ELIGIBILITY.—Section 614(c)(5)(B)(ii) of the Individuals with Disabilities Education Act (20 U.S.C. 1414(c)(5)(B)(ii)) is amended—

(1) by striking "the child with a summary" and inserting "to the child and the child's parents, not later than 7 days after the child's eligibility terminates, with—

"(I) a summary";

(2) by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new subclause:

"(II) a comprehensive record of the child's work experiences, skills,

talents and strengths relevant for discussions with prospective employers, post-secondary education programs, career placement services, and mentors.".

(b) INDIVIDUALIZED EDUCATION PROGRAM.—Section 614(d)(1)(A) of the Individuals with Disabilities Education Act (20 U.S.C. 1414(d)(1)(A)) is amended—

(1) in clause (i)—

(A) in subclause (VII), by striking "and" at the end;

(B) in subclause (VIII)—

(i) in the matter preceding item (aa)—

(I) by striking "16" and inserting "14"; and

(II) by inserting "at a minimum" after "updated"; and

(ii) by striking items (bb) and (cc) and inserting the following:

"(bb) a strategy to address the needs of the child related to academic and school-based preparatory experiences, work and career readiness, youth develop-

ment and leadership, comprehensive community connections, and family involvement and engagement; and

"(cc) objectives leading to postsecondary education, sustained integrated employment, economic self-sufficiency, independent living and community participation;"; and

(C) by adding at the end the following:

"(IX) beginning not later than the date on which the first IEP is to be in effect when the child attains the age of 14—

"(aa) a description of the transition services (including courses of study and work experience) that will be provided to assist the child in reaching the postsecondary goals described in subclause (VIII)(aa); and

"(bb) a description of the training in self-advocacy, development of self-determination activi-

ties, and the skills needed to participate in making informed choices to prepare and empower the child to negotiate and advocate on the child's own behalf; and

"(X) beginning not later than 1 year before the child reaches the age of majority under State law, a statement that the child and the child's parents have been informed of the child's rights under this title, if any, that will transfer to the child on reaching the age of majority under section 615(m).''; and

(2) by adding at the end the following:

"(iii) ADDITIONAL RULE OF CONSTRUCTION.—Nothing in clause (i)(VIII) shall be construed to authorize the use of facility-based employment or activity settings, such as sheltered workshops, day habilitation centers, mobile work crews, or enclave work settings in a child's IEP.''.

(c) INDIVIDUALIZED EDUCATION PROGRAM TEAM.—Section 614(d)(1)(B) of the Individuals with Disabilities Education Act (20 U.S.C. 1414(d)(1)(B)) is amended—

(1) in clause (vi), by striking "and" at the end;

(2) redesignating clause (vii) as clause (viii); and

(3) by inserting after clause (vi), as amended by this subsection, the following:

"(vii) beginning at the age of 14 with respect to a child with a disability who is expected to be eligible to receive adult services under the State medicaid program under title XIX of the Social Security Act (or any services provided under a waiver under such program) or any other adult services provided by the State intellectual and developmental disabilities agency upon reaching the age of majority, a representative of the State intellectual and developmental disabilities agency; and".

(d) DEVELOPMENT OF IEP.—Section 614(d)(3) of the Individuals with Disabilities Education Act (20 U.S.C. 1414(d)(3)) is amended—

(1) in subparagraph (A)—

(A) in clause (iii), by striking "and" at the end;

(B) in clause (iv), by striking the period at the end and inserting "; and"; and

(C) by adding at the end the following:

"(v) the transition services necessary to assist the child to attain a postsecondary education, integrated employment, independent living, and community participation."; and

(2) by redesignating subparagraphs (B) through (F) as subparagraphs (C) through (G), respectively;

(3) by inserting after subparagraph (A) the following new subparagraph:

"(B) PREPARATION FOR DEVELOPMENT OF IEP FOR A CHILD IN TRANSITION YEARS.—The IEP Team, upon the request of a child who has attained the age of 14, shall—

"(i) offer a preliminary meeting and advocacy training for the child and child's parents to support the preparation of the parents in advocating on their child's behalf during any upcoming IEP team meeting that will be conducted by a certified

of an IEP for children with disabilities under this part; and

"(B) facilitate relationships between children with disabilities and parents of children with disabilities and public and private agencies involved in transition services for children with disabilities under this part.

"(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection $50,000,000 for fiscal year 2012 and each subsequent fiscal year.".

SEC. 8. EFFECTIVE DATE.

The amendments made by this Act take effect on the date of the enactment of this Act and apply with respect to fiscal years beginning on or after the date of the enactment of this Act.

tives, identifying challenges and opportunities and discussing any additional transition services that need to be secured to optimize the child's successful completion of transition objectives set forth in the child's IEP leading to postsecondary education, integrated employment, independent living, and community participation.".

SEC. 7. GRANTS FOR ESTABLISHMENT OF LOCAL COORDINATORS FOR TRANSITION SERVICES.

Section 614 of the Individuals with Disabilities Education Act (20 U.S.C. 1414) is amended by adding at the end the following:

"(g) GRANTS FOR ESTABLISHMENT OF LOCAL COORDINATORS FOR TRANSITION SERVICES.—

"(1) IN GENERAL.—The Secretary is authorized to provide grants to State educational agencies to provide authorization, funding, and support to local educational agencies to establish coordinators to provide transition services to children with disabilities under this part.

"(2) ACTIVITIES OF COORDINATORS.—Coordinators established under paragraph (1) shall—

"(A) manage the development and implementation of the transition services components

trainer with specific experience in self-advocacy and family advocacy training; and

"(ii) ensure that all pertinent information, including school records, educational materials regarding transition services available and background information on any pre-existing partnerships between the local educational agency and any outside providers of transition services or post-secondary education, is sent to the child at least ten days prior to the IEP team meeting."; and

(4) in subparagraph (G) (as redesignated), by striking "subparagraph (D)" and inserting "subparagraph (E)".

(e) REVIEW AND REVISION OF IEP.—Section 614(d)(4)(A) of the Individuals with Disabilities Education Act (20 U.S.C. 1414(d)(4)(A)) is amended—

(1) in clause (i), by striking "and" at the end;

(2) in clause (ii), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following:

"(iii) beginning when the child attains the age of 14, evaluates the progress made in achieving the child's transition objec-

[DISCUSSION DRAFT]

JANUARY 20, 2011

112TH CONGRESS
1ST SESSION

H. R. _____

To amend the Rehabilitation Act of 1973 to authorize grants for the transition of youths with significant disabilities to adulthood, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mr. HARPER introduced the following bill; which was referred to the Committee on _____

A BILL

To amend the Rehabilitation Act of 1973 to authorize grants for the transition of youths with significant disabilities to adulthood, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the [“_____ Act of 2011”].

SEC. 2. DEFINITIONS.

(a) ASSESSMENT FOR DETERMINING ELIGIBILITY AND VOCATIONAL REHABILITATION NEEDS.—Section 7(2) of the Rehabilitation Act of 1973 (29 U.S.C. 705(2)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking "and" at the end;

(B) in clause (ii), by adding "and" at the end; and

(C) by adding at the end the following new clause:

"(iii) with respect to a person who is an individual with a significant disability or an individual with a most significant disability, [NOTE: To be supplied]"; and

(2) in subparagraph (B)—

(A) in clause (iii), by striking "and" at the end;

(B) in clause (iv), by adding "and" at the end; and

(C) by adding at the end the following new clause:

"(v) uses, to the maximum extent possible, information obtained from experiences in integrated employment settings in

the community and other integrated community settings, and does not include information from assessments of experiences in sheltered workshops and similar segregated settings;".

(b) SUPPORTED EMPLOYMENT.—Section 7(35) of the Rehabilitation Act of 1973 (29 U.S.C. 705(35)) is amended by adding at the end the following new subparagraph:

"(C) MINIMUM COMPENSATION REQUIREMENTS.—Such term includes, to the maximum extent practicable, employment that meets the following requirements:

"(i) The provision of minimum and prevailing wages that are paid for by the employer.

"(ii) The provision of related health and employment benefits that are comparable to benefits provided to other employees of the employer.

"(iii) The placement in individual and not an enclave or group settings.".

(c) SUPPORTED EMPLOYMENT SERVICES.—Section 7(36) of the Rehabilitation Act of 1973 (29 U.S.C. 705(36)) is amended [NOTE: Serena will send new language].

(d) TRANSITION SERVICES.—Section 7(37) of the Rehabilitation Act of 1973 (29 U.S.C. 705(37)) is amended [NOTE: Serena will send new language].

SEC. 3. DEMONSTRATION AND TRAINING PROGRAMS.

(a) IN GENERAL.—Section 303(b)(1) of the Rehabilitation Act of 1973 (29 U.S.C. 773(b)(1) is amended by adding at the end the following new sentence: "The Commissioner may provide up to 10 grants to or enter into 10 contracts with (or a combination thereof, not to exceed a total of 10 grants and contracts) eligible entities under this subsection during a fiscal year. A grant provided or contracted entered into under this subsection shall be provided or entered into, as the case may be, for a period of five years. An eligible entity may not receive more than one grant or enter into more than one contract during a five-year period.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on the date of the enactment of this Act and applies with respect to grants provided under section 303(b) of the Rehabilitation Act of 1973 for fiscal years beginning on or after the date of the enactment of this Act.

SEC. 4. GRANTS FOR TRANSITION OF YOUTHS WITH SIGNIFICANT DISABILITIES TO ADULTHOOD.

(a) IN GENERAL.—Title III of the Rehabilitation Act of 1973 (29 U.S.C. 771 et seq.) is amended by adding at the end the following new section:

"SEC. 307. GRANTS FOR TRANSITION OF YOUTHS WITH SIGNIFICANT DISABILITIES TO ADULTHOOD.

"(a) DEFINITIONS.—In this section:

"(1) BRAIDED FUNDING.—The term 'braided funding' means a resource utilization strategy to maximize access to existing funding through the coordination, sequencing, and integration of available funding from multiple public agencies and private sources.

"(2) CUSTOMIZED EMPLOYMENT STRATEGIES.—[NOTE: Serena will send new language] [NOTE: Term only is used once. Instead of a definition, the term could be described in detail where it appears in the text]

"(3) INTEGRATED [NOTE: TO BE SUPPLIED].—[NOTE: Serena will send new language] [NOTE: 'Integrated' appears a substantial number of times with different terms following it.]

"(4) PERSON-CENTERED PLANNING PROCESS.—The term 'person-centered planning process' means a process that enables and assists a youth with a

significant disability to identify and access a personalized mix of paid and non-paid services and supports that will assist such youth to achieve personally-defined outcomes in the most inclusive community setting. [NOTE: Still not sure what these words mean.]

"(5) STATE DEVELOPMENTAL DISABILITY AUTHORITY.—The term 'State Developmental Disability Authority' means the primary State agency or subdivision with administrative, programmatic, and operational responsibility for the full range of services and supports furnished to individuals with developmental disabilities.

"(6) YOUTH WITH A SIGNIFICANT DISABILITY.—In this subsection, the term 'youth with a significant disability' means an individual with a significant disability who has attained the age of 14 but has not attained the age of 27.

"(b) GRANTS.—

"(1) IN GENERAL.—For each of the fiscal years 2012 through 2016, the Assistant Secretary for Special Education and Rehabilitative Services, in cooperation with the officials specified in paragraph (2), is authorized to provide grants to eligible enti-

ties to carry out the activities authorized under this section.

"(2) OFFICIALS SPECIFIED.—The officials specified in this paragraph are the Commissioner of the Agency on Developmental Disabilities, the Director of Medicaid Operations at the Centers for Medicare and Medicaid Services, and the Assistant Secretary of Labor for Disability Employment Policy.

"(3) NUMBER OF GRANTS; DURATION; NUMBER OF GRANTS PER ELIGIBLE ENTITY.—The Assistant Secretary for Special Education and Rehabilitative Services may provide up to 10 grants under this subsection during a fiscal year. A grant provided under this subsection shall be provided for a period of five years. An eligible entity may not receive more than one grant during a five-year period.

"(c) ELIGIBLE ENTITIES.—To be eligible to receive a grant under subsection (a), an entity shall be a consortium that—

"(1) consists of and is managed by, at a minimum, representatives from the State educational agency, the State Developmental Disability Authority, the State vocational rehabilitation agency, the State Medicaid agency, the State department of

labor and workforce investment board, and the State department of higher education;

"(2) includes stakeholders who will be involved in the planning and implementation of funds made available through the grant, including—

"(A) representatives from the National Network of University Centers for Excellence in Developmental Disabilities Education, Research, and Service, State protection advocacy and client assistance programs, and centers on independent living; and

"(B) representatives from self-advocacy organizations and family organizations; and

"(3) includes additional public and private individuals and entities with demonstrated expertise in providing post-secondary educational opportunities and integrated employment services for individuals with significant disabilities and individuals with the most significant disabilities with expertise in the provision of supported employment services and customized employment strategies and that—

"(A) provide services resulting in integrated post-secondary education outcomes or integrated employment outcomes at minimum and

prevailing wages with access to related health and employment benefits;

"(B) have expertise in person-centered planning processes; or

"(C) have experience operating mentoring programs for individuals with significant disabilities and individuals with the most significant disabilities in middle schools and secondary schools in culturally and socioeconomically diverse communities.

"(d) APPLICATION.—An eligible entity that desires to receive a grant under subsection (a) shall submit to the Assistant Secretary for Special Education and Rehabilitative Services an application at such time, in such manner, and including such information as the Assistant Secretary may require. Each application shall include—

"(1) an implementation plan, including the identification of the lead agency by the State, describing the actions the entity intends to take to carry out the activities authorized under this subsection;

"(2) assurances that a memorandum of understanding among the participating State agencies will be developed outlining key steps to be taken to collaborate and coordinate efforts to institute systemic

change, including braided funding, focused on improving post-secondary education and employment outcomes for individuals with significant disabilities and individuals with the most significant disabilities, and integrated settings at minimum and prevailing wages with access to related employment and health benefits, leading to optimal self-sufficiency and economic security of such individuals;

"(3) a description of the means and mechanisms by which participating State agencies will coordinate efforts to evaluate and reform existing State laws, regulations, guidelines, operational procedures, and funding practices, including braided funding, to institute systemic change focused on improving post-secondary education and employment outcomes in integrated settings at minimum and prevailing wages with access to related employment and health benefits, leading to optimal self-sufficiency and economic security of individuals with significant disabilities and individuals with the most significant disabilities;

"(4) an evaluation plan describing the strategy the entity will use to evaluate the use of funds made available through the grant, with a specific focus on the collection of data (by age, race, gender, geo-

graphic area, type of disability, income level, communication level, and use of assistive technology) tracking, at a minimum—

"(A) the number of individuals with significant disabilities and individuals with the most significant disabilities who directly enter integrated employment opportunities paid at minimum and prevailing wages with access to related employment and health benefits, or a post-secondary educational or training program that is focused on leading to an integrated employment outcome, upon exiting the school system;

"(B) the wages and number of hours worked of individuals per pay period;

"(C) the impact of employment on any State and Federal benefits received;

"(D) indicators on the types of settings in which the individuals benefitting from the State grant primarily reside;

"(E) indicators of improved economic status and self-sufficiency;

"(F) data on those individuals for whom a post-secondary or employment outcome in an integrated setting has not yet occurred, includ-

ing information on why such outcome has not yet been attained, and additional information such as the number of months an individual has not had an employment outcome in an integrated setting and the progress made to date on efforts to ensure that an individual achieves a post-secondary education or employment outcome in an integrated setting at minimum and prevailing wages with access to related employment and health benefits leading to optimal self sufficiency and economic security [shall be collected]; and

"(G) location and type of settings of where youth who are individuals with significant disabilities or individuals with the most significant disabilities who are receiving services through the grant are living;

"(5) a description of the ways in which the eligible entity will disseminate information about the activities and the impact of the activities on the lives of youth who are individuals with significant disabilities and individuals with the most significant disabilities who are served by the project; and

"(6) a description of the approaches the eligible entity intends to use to coordinate activities with

other relevant service providers in the localities in which the activities of the grant will be focused.

"(e) AUTHORIZED ACTIVITIES.—An entity that receives a grant under this subsection shall use the funds made available through the grant to carry out the following activities for youths with significant disabilities:

"(1) The development of innovative and effective practices through person-centered planning processes for attaining integrated employment experiences at minimum and prevailing wages, including employment after school, on weekends, and in the summer months.

"(2) The development of objectives and activities based upon the highest expectations of youths with significant disabilities and related to the following areas:

"(A) Academic and school-based preparatory experiences, including access to the general education curriculum in the least restrictive environment.

"(B) Work and career readiness.

"(C) Self-determination and leadership.

"(D) Comprehensive community connections.

"(E) Life-long learning.

"(F) Family involvement and engagement.

"(3) The development of appropriate and effective curricula and the deployment of professionals with expertise to provide training to school personnel, including transition coordinators, and other personnel connected to the implementation of the implementation plan of the grantee to enable such school personnel to develop skills needed to assist such youths in actualizing their ability to obtain and maintain integrated employment at minimum or prevailing wages. Such training shall be focused on developing the skills in personnel necessary to help such youths successfully identify and complete desired objectives in the following areas:

"(A) Academic and school-based preparatory experiences, including access to the general education curriculum in the least restrictive environment.

"(B) Work and career readiness.

"(C) Youth development and leadership.

"(D) Comprehensive community connections.

"(E) Family involvement and engagement.

"(4) The provision of assistance to youths with significant disabilities and their families with respect

to determining appropriate services under relevant Federal and State programs, to include the following:

"(A) An informed decision process leading to an employment outcome and securing ongoing services required for sustaining the employment outcome.

"(B) A benefits planning process in order to educate youths with significant disabilities regarding strategies for identifying, optimizing and managing available benefits and resources.

"(C) A series of individualized economic advancement strategies to advance the optimal self-sufficiency and economic security of a youth who is an individual with a significant disability or an individual with the most significant disability with specific asset goals, including the use of favorable tax benefits, work incentives, matched savings plans, and financial education.

"(f) PROHIBITED ACTIVITIES.—

"(1) IN GENERAL.—Funds made available through a grant under subsection (a) may not be used for activities that result in youths with significant disabilities being placed in center-based services as an employment outcome or post-secondary out-

come. In this paragraph, the term 'center-based services' means sheltered workshops, day habilitation, or any other similar settings.

"(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to prohibit any youth with a significant disability from having access to the general education curriculum during the pursuit of transition services or post-secondary education outcomes.

"(g) EMPLOYMENT OUTCOMES AND EVALUATION.—

"(1) OUTCOMES.—An entity that receives a grant under this section shall collect data and report annually on, at a minimum, progress in achieving specific employment outcomes outlined by the Assistant Secretary for Special Education and Rehabilitative Services. Such outcomes shall include the following:

"(A) The number of individuals with significant disabilities and individuals with the most significant disabilities who directly enter integrated employment opportunities paid at minimum wage or higher with commensurate benefits upon exiting the school system.

"(B) The types of positions and employment sectors the individuals with significant

disabilities and individuals with the most significant disabilities are participating in, as defined by the Bureau of Labor Statistics of the Department of Labor.

"(C) The wages of and number of hours worked by individuals with significant disabilities and individuals with the most significant disabilities monthly.

"(D) The impact of employment on any Federal and State benefits received.

"(E) Indicators of improved economic status and self-sufficiency.

"(F) Data on those individuals with significant disabilities and individuals with the most significant disabilities who have not yet been placed in an integrated employment opportunity, outlining the reasons that the individuals with significant disabilities and individuals with the most significant disabilities was not placed in an integrated employment position as well as the progress made to date in the acquisition of skills, training, and development necessary to attain an integrated employment opportunity at minimum wage or higher with commensurate benefits.

"(2) CENTER.—There is established a National Coordination Center on Systems Change and Transformation in the Transition of Youths with Significant Disabilities into Adulthood (in this paragraph referred to as the 'Center') to coordinate personnel training and professional development in evidenced-based best practices resulting in employment outcomes. The Center shall coordinate assistance with the state grantees and their leadership teams and support grantees in their systems change efforts.

"(h) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—There are authorized to be appropriated to carry out this section (other than subsection (g)(2)) $50,000,000 for each of the fiscal years 2012 through 2016.

"(2) CENTER.—There are authorized to be appropriated to carry out subsection (g)(2) $5,000,000 for each of the fiscal years 2012 through 2016.".

(b) CLERICAL AMENDMENT.—The table of contents for the Rehabilitation Act of 1973 is amended by inserting after the item relating to section 306 the following new item:

"Sec. 307. Grants for transition of youths with significant disabilities to adulthood.".

AGENDA ITEM DETAIL SHEET

ISSUE: Area Board Legislative Update

BACKGROUND: The Legislative and Public Policy Committee (LPPC) will hear an update regarding the legislative activities of area boards.

ANALYSIS/DISCUSSION: Report only

COUNCIL STRATEGIC PLAN OBJECTIVE: Advance the rights and abilities of all Californians with developmental disabilities and their families to exercise self-advocacy and self-determination.

Shape public policy that positively impacts Californians with developmental disabilities and their families.

PRIOR LPPC/COUNCIL ACTIVITY: The LPPC has requested area boards provide them with legislative updates.

RECOMMENDATION(S): None

ATTACHMENT(S): None

PREPARED: Christofer Arroyo, February 3, 2011

AGENDA ITEM DETAIL SHEET

ISSUE: Policy Issues

BACKGROUND: The Council has directed the Legislative and Public Policy Committee (LPPC) to write policies that guide Council action.

ANALYSIS/DISCUSSION: At the October 2010 LPPC meeting, the Committee reviewed a draft public benefits policy paper and made recommendations for changes to the authors. The authors have resubmitted the revised paper for LPPC action.

Also in October 2010, LPPC reviewed suggested changes to the policy on special education and recommended it be returned to the Committee for potential action.

COUNCIL STRATEGIC PLAN OBJECTIVE: Advance the rights and abilities of all Californians with developmental disabilities and their families to exercise self-advocacy and self-determination.

Shape public policy that positively impacts Californians with developmental disabilities and their families.

PRIOR LPPC/COUNCIL ACTIVITY: The Council has approved a policy addressing special education. The LPPC discussed the need to revise the policy on special education so it conforms to other Council policies.

RECOMMENDATION(S): LPPC approve the revised policy on public benefits and special education and submit them to the Council for approval.

ATTACHMENT(S):

1) Draft policy on public benefits
2) Council approved policy on special education
3) Marilyn Barraza's proposed edits of the policy on special education
4) Jorge Aguilar's response to the proposed edits to the policy on special education

PREPARED: Christofer Arroyo, February 3, 2011

Draft

POLICY ON PUBLIC BENEFITS FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

Background:

Public Benefits are necessary for people with developmental disabilities to ensure that they do not become ill-housed, ill-clad, or ill-fed, and that they have access to needed medical services. The benefit programs that are required to keep people with developmental disabilities healthy, independent, and integrated into society are provided by various levels of government and private non-profit organizations working together.

Principles:

1. The State Council supports improving income and medical benefits programs to allow disabled people to work more hours in the community;

2. The Council supports expansion and improving the flexibility of Section 8 housing vouchers;

3. The Council supports efforts to improve Universal Lifeline Telephone Service including its expansion to wireless phone providers;

4. The Council supports the California Alternate Rate for Energy Program (CARE Program) for natural gas and electric power service.

5. The Council supports controls and regulations governing utilities termination of service to customers with disabilities;

6. The Council supports allowing people with developmental disabilities to maintain special bank accounts that would be used for such special purposes as buying a home or condo, or setting up a micro-enterprise, among others;

7. The Council supports private insurance coverage to cover care and treatment of all developmental disabilities.

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POLICY 2010-01: ON SPECIAL EDUCATION

Adopted 2010-03-16 : Last Amended - NA -

BACKGROUND:

The right of every individual to receive a meaningful education is a basic civil right that is well established in the records of our country and by international agreements. It is in the interest of the general welfare that the citizens of our country be educated so as to be better equipped to be productive members of their community and better contribute to society. The equal protection clause of the Fourteenth Amendment to the U.S. Constitution requires states to provide equal protection under the law to citizens of the United States. Even with states steeped in the mandate under the Fourteenth Amendment, it was not until 1954, when the U.S. Supreme Court decided *Brown versus Board of Education of Topeka*, in which the Court held that education "is a right which must be made available to all on equal terms". In recognition that equal education for all was a civil rights issue the Court wrote:

> "Today, education is perhaps the most important function of state and local governments. Compulsory school attendance laws and the great expenditures for education both demonstrate our recognition of the importance of education to our democratic society. It is the very foundation of good citizenship. Today, it is a principal instrument in awakening the child to cultural values, in preparing him for later professional training, and in helping him adjust normally to his environment. In these days, it is doubtful that any child may reasonably be expected to succeed in life if he is denied the opportunity of an education. Such opportunity, where the state has undertaken to provide it, is a right that must be made available to all on equal terms."[1]

In the international forum, the United Nations General Assembly enshrined the right of every individual to receive an education in the *1948 Universal Declaration of Human Rights* and in a renewing pledge made by the world community at the *1990 World Conference on Education for All* to ensure the right to a meaningful education for all regardless of individual differences.

In 1964 Congress passed the *Civil Rights Act of 1964*. This historic legislation not only encouraged the desegregation of public schools, but it also barred discrimination on the basis of race, religion, gender, or ethnicity. Providing a broad framework to advocate

[1] *Brown v. Board of Education*, 347 U.S. 483 (1954)

for equal rights to access public resources, the Act also laid the foundation for special education.

Following on the heels of the *Civil Rights Act of 1964*, in 1965 Congress enacted the *Elementary and Secondary Education Act* (ESEA) to address the inequality of educational opportunity for many underprivileged children. This landmark legislation provided a foundation to help ensure disadvantaged students had access to quality education. In 1966 Congress acted quickly in amending ESEA to encourage improvement in the education of children with disabilities. The National Council on Disability (NCD), an independent federal agency, noted:

> "Congress first addressed the education of students with disabilities in 1966 when it amended the *Elementary and Secondary Education Act of 1965* to establish a grant program to assist states in "initiation, expansion, and improvement of programs and projects....for the education of handicapped children." In 1970, that program was replaced by the *Education of the Handicapped Act* (P.L. 91-230) that, like its predecessor, established a grant program aimed at stimulating States to develop educational programs and resources for individuals with disabilities. Neither program included any specific mandates on the use of the funds provided by the grants; nor could either program be shown to have significantly improved the education of children with disabilities."[2]

Again, with the drive to be free of discrimination, the *Rehabilitation Act of 1973* was the first of its kind, whereby Section 504 of this Act prohibited discrimination on the basis of disability. Additionally, the provisions were enforceable in court.

Despite the decisions of the United States Supreme Court and the equal rights momentum demonstrated in historic legislative acts, equal educational rights for students with disabilities did not exist. Public schools in the United States were still essentially closed to children with disabilities. Schools were ***not required*** to educate or even enroll children with developmental or other disabilities. Across the country court cases showed resistance by the established educational system to allow children with disabilities access to the same educational opportunities as their able-bodied peers. Equal educational rights for students with disabilities were not fully established until 1974, with the passage of PL 94-142, the *Education of All Handicapped Children Act (EAHCA)*. In 1990 EAHCA was renamed the Individuals with Disabilities Education Act (IDEA).

Today, with the weight of history and many pillars to support it, the federal special education law now known as the *Individuals with Disabilities Education and Improvement Act*, or IDEIA, promises millions of American children with disabilities access to a free and appropriate public education. Special education is now not a placement, but a service and children with disabilities, from birth to 21, are to be guaranteed access to specially designed instruction and related services through the development and implementation of an Individualized Education Program (IEP). It is intended that no child can legally be denied a free, appropriate, public education based upon his or her disability.

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[2] *Back to School on Civil Rights*, published by the National Council on Disability (2000)

However, despite real progress made since 1974, significant work remains to be done to ensure that the promise of an "appropriate" education to all students with disabilities is kept. Too many children with disabilities continue to be denied the basic civil right of a meaningful education, frequently receiving services of trivial benefit, facing low expectations, and exclusion from regular classrooms. Congress too has noted these continuing problems and the intent to address in Section 1400 "Findings and Purpose" of the IDEA statute:

> "However, the implementation of this title has been impeded by low expectations, and an insufficient focus on applying replicable research on proven methods of teaching and learning for children with disabilities." "Almost 30 years of research and experience has demonstrated that the education of children with disabilities can be made more effective by... having high expectations for such children... meet developmental goals and, to the maximum extent possible, the challenging expectations that have been established for all children; and be prepared to lead productive and independent lives to the maximum extent possible... strengthening the role and responsibility of parents ... coordinating this title with ... Elementary and Secondary Education Act of 1965"[3]

It is abundantly clear that the intent from Congress and from the historical recognition of the basic civil right to an education for <u>all</u> children receiving special education services are first and foremost general education children. A disability should not segregate an individual any more than should height, athletic ability, race or religious belief. Despite this basic fact, many (including educators and policy-makers) think of general education and special education as two separate systems and place them in competition with each other for attention and allocation of resources. According to the report by the President's Commission on Special Education, the bureaucratic imperatives of the system are focused on compliance with established procedures rather than academic achievement and this focus fails too many children. [4] In reliance on compliance schools and the courts have often cited the first special education case decided by the U.S. Supreme Court in 1982 based on the 1975 EAHCA known as "Rowley"[5] Many Local Education Agencies (LEA's) and judicial opinions still rely on the most minimal standards based on "access to" and "some benefit" from that access that are quoted in the Rowley opinion even though that was based on a time when even allowing children with disabilities to attend a public school was at issue. Some LEA's and the hearing courts have not recognized the intent of moving beyond the most basic "access" and "some benefit" standards to those of providing meaningful education opportunities for future productive and independent adult living as outlined in the language of the current IDEIA.

Schools must do more to ensure that students with disabilities receive a meaningful education based on their individual potential with the same high expectations as for all children. Students with disabilities must be allowed real access to and inclusion in the general curriculum with needed accommodations, modifications and/or supports as well as access to assistive technology. Schools must concentrate on opening the doors to meaningful inclusion in the community of school for students with disabilities, including

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[3] *20 U.S.C. 1400(c)(4-5)*
[4] *"A New Era: Revitalizing Special Education for Children and Their Families", (2002)*
[5] *Board of Education of Hendrick Hudson Central School District v. Rowley, 1982*

ensuring access to extracurricular activities. Efforts to assist students' transition from school to work or post-secondary studies and meaningful access to and inclusion in the daily life of our communities must be enhanced; too many youth with disabilities are still leaving school unprepared for life as adults.

Special education should be focused on providing those supports and services which allow the closing of the achievement gap between children with disabilities and their typically developing peers. IDEA includes not only the express intent for inclusion and high expectations in the education of children with disabilities but also strengthens the role of parents by full participation as a primary part of the Individualized Education Program (IEP) planning team that decides the appropriate special education supports and services alongside school district staff. To enforce full participation, IDEA includes not only procedural safeguards but also "Due Process" procedures in case of disagreement between team members. In case of disagreement, a Local Education Agency is able to state what it is willing to offer as a Free Appropriate Public Education (FAPE) and the parent may agree or not, then either party desiring a change in the IEP would initiate a due process. According to data from the NCD there are significant issues in the implementation and outcome of special education services that would be expected to result in a large percentage of enforcement cases brought forward to litigation:

> "- a deep chasm of opinion on a number of issues particularly relevant to the quality of educational outcomes for students with disabilities. From the students, we hear the reality of their lives in special education. In most cases, the comments we received from them are a scathing indictment of the implementation of IDEA." [6]

In the State of California approximately 700,000 children receive special education services and supports and the "Due Process" is administered by a quasi-judicial state agency known as the Office of Administrative Hearings (OAH, an agency under the executive branch of civil service). During fiscal year 2005-06, approximately 4,012 cases (approximately 0.6%) were filed with the OAH by families who did not agree with the level of supports, services or placement their children received from local school districts (38% of the filings were regarding assessment, while 51% regarded placement). Despite the fact that California has a comprehensive due process procedure in place (to appeal decisions of the schools) it appears that families have tended not to utilize the system –as reported by families, in part because the system is so difficult to understand and the process appears to favor the agency over the family. Agencies are more familiar with the system and better able to mount a judicial process than families of children with disabilities. Many families with children that have disabilities struggle financially and are stretched to maintain the stability of the home environment. The Local Educational Agency has employees and legal resources paid by public funds to mount a "Due Process" litigation whereas the family must rely on the limited time and resources of the parents. Additionally, because of the complexity and odds of the process, families are unable to find free and/or low cost representation in most cases. It is commonly understood by both families and agency representatives that "it is not an even playing field". Advocates report that the inequity of the system has intimidated many family members of the IEP and in some cases emboldened

[6] "*Individuals With Disabilities Education Act Reauthorization: Where Do We Really Stand", (2002)*

agency members of the IEP. Family members and advocacy groups have grown increasingly concerned with the apparent inequities of the resolution process and the actual versus required impartiality of the system.

PRINCIPLES:

The State Council on Developmental Disabilities understands the importance of preparing all students for independent living and engaged and productive participation in the richness of our society. The State Council on Developmental Disabilities promotes implementation of high quality special education programs as an integral part of the general education community with transparent and impartial monitoring by the following actions:

1. As driven by the weight of history and legislative action, special education is a fundamental civil right, an integral part of the general education program, and a legal mandate. With values such as integration and inclusion replacing inequality and segregation, public education is a means to achieve social participation, productivity, and greater self-reliance leading to independent living to the maximum extent possible. Therefore, the State Council on Developmental Disabilities supports the strengthening or expansion of existing programs and/or creation of new programs to advocate for the right of all students with disabilities to receive a meaningful and free, appropriate, public education. Further, to improve upon outcomes leading to independent living to the maximum extent possible, the State Council on Developmental Disabilities supports early and continuous opportunities and actions to improve the transition from high school to adulthood.

2. With the scarcity of resources, some attitudes are expressed that reflect a belief that special education funding and resourcing usurps, or encroaches upon, resources that should go to general education programs (termed encroachment). Because such ideology discriminates against students with disabilities, the State Council on Developmental Disabilities promotes the civil rights of students with disabilities to be free of educational discrimination. The State Council on Developmental Disabilities will promote and partner with other to promote public outreach and education activities that reflect the values that students receiving special education services are part of the general education population and an integral part of their community.

3. Many families have reported extreme difficulty and experienced gaps in services during the transition from early intervention services (Part C services) to special education (Part B services) at age 3. Additionally, much research has been done that demonstrates the importance of children with disabilities receiving services during this critical period of neurodevelopment. A previous safeguard during this transition allowed children to continue receiving the services families had agreed to while attempting to resolve any disagreements in due process. However, that safeguard, termed "Stay Put", was lost for this transition period. Therefore, the State Council on Developmental Disabilities supports the return of this provision, as well as other provisions, that level the playing field between students with disabilities and schools.

4. As evidenced by the large percentage of appeals cases surrounding assessment and placement, many families have reported that IEP's are built on low expectations and that school staff undervalue or ignore their input regarding their children's ability

and potential. The State Council on Developmental Disabilities supports the use of assessments and systems that allow for effective identification of students who may be eligible to receive special education, effective assessments of individual needs, which include objective standardized assessments that are supplemented by parental input and other observational data. The Council supports the development of IEP goals that are accurately and appropriately based upon students' abilities and their developmental potential. The Council also supports schools maintaining high expectations that conform, to the maximum extent possible, as close to the California Department of Education's content standards and age appropriate developmental criteria.

5. In order to accurately assess the short- and long-term progress of students, the State Council on Developmental Disabilities supports annual and long term tracking of the progress of students with IEPs relative to standardized norms and to the general student population of their school community. Such tracking will assist schools and students in mutually monitoring their accountability to each other.

6. In following federal and California legal mandates, the State Council on Developmental Disabilities supports the identification and usage of peer reviewed, researched based methodologies to develop instructional strategies, services, and supports for IEPs as measured by implementation outcomes.

7. The operational effect of the law is the interplay of legislation, regulations developed by state and federal agencies, and case law created in courts. Because some issues may require clarification and/or update and because of this interplay, the State Council on Developmental Disabilities promotes education in support of legislative activities that clarify the intent and limitations behind out-of-date case law, legislation, and/or regulations.

8. To better measure the needs, frustrations, and satisfaction of families of children with developmental disabilities, the State Council on Developmental Disabilities supports the use of surveys regarding satisfaction with IDEA implementation by state and local educational agencies including but not limited to: the assessment of children, the identification of the appropriate services and supports to address needs, the definition of goals, objectives and the measurement of progress, the resolution, due process and appeals procedures, and other issues as appropriate.

9. Because of lack of clarity and concerns with how public funding is used by schools, the State Council on Developmental Disabilities supports the development of standards which promote the transparency of reporting on the use of public resources for purposes which include but are not limited to the funding special education receives as a percentage of total gross funding, funding devoted to each service and support by category, and cumulative annual and segregate case legal fees paid by each school district to attorneys.

10. In order to be effective in achieving the above actions and further advocacy on behalf of children with disabilities and their families, the State Council on Developmental Disabilities supports working with other advocacy groups, local, state and federal partnerships to coordinate actions, resources and identify areas of improvement related to special education.

BARRAZA SUGGESTED EDITS

POLICY 2010-01: ON SPECIAL EDUCATION

Adopted 2010-03-16 : Last Amended - NA –

BACKGROUND:

The right of every individual to receive a meaningful education is a basic civil right that is well established in the records of our country ~~and by international agreements~~. It is in the interest of the general welfare that all the citizens of our country be educated so as to
be better equipped to be productive members of their community and better contribute to society. ~~The equal protection clause of the Fourteenth Amendment to the U.S. Constitution requires states to provide equal protection under the law to citizens of the United States. Even with states steeped in the mandate under the Fourteenth Amendment, it was not until 1954, when~~ In 1954 the U.S. Supreme Court ~~decided~~ ruled in *Brown versus Board of Education of Topeka*, ~~in which the Court held~~ that education "is a right which must be made available to all on equal terms". In recognition that equal education for all was a civil rights issue the Court wrote:

> "Today, education is perhaps the most important function of state and local governments~~... Compulsory school attendance laws and the great expenditures for education both demonstrate our recognition of the importance of education to our democratic society. It is the very foundation of good citizenship. Today, it is a principal instrument in awakening the child to cultural values, in preparing him for later professional training, and in helping him adjust normally to his environment.~~ In these days, it is doubtful that any child may reasonably be expected to succeed in life if he is denied the opportunity of an education. Such opportunity, where the state has undertaken to provide it, is a right that must be made available to all on equal terms."1

~~In the international forum, the United Nations General Assembly enshrined the right of every individual to receive an education in the *1948 Universal Declaration of Human Rights* and in a renewing pledge made by the world community at the *1990 World Conference on Education for All* to ensure the right to a meaningful education for all regardless of individual differences.~~

In 1964 Congress passed the *Civil Rights Act of 1964*. This historic legislation not only encouraged the desegregation of public schools, but it also barred discrimination on the basis of race, religion, gender, or ethnicity. Providing a broad framework to advocate

1 *Brown v. Board of Education*, 347 U.S. 483 (1954)

for equal rights to access public resources, the Act also laid the foundation for special education.

Following on the heels of the *Civil Rights Act of 1964*, iIn 1965 Congress enacted the *Elementary and Secondary Education Act* (ESEA) to address the inequality of educational opportunity for many underprivileged children. This landmark legislation provided a foundation to help ensure disadvantaged students had access to quality education. In 1966 Congress acted quickly in amending ESEA to encourage improvement in the education of children with disabilities. The National Council on Disability (NCD), an independent federal agency, noted:

> "Congress first addressed the education of students with disabilities in 1966 when it amended the *Elementary and Secondary Education Act of 1965* to establish a grant program to assist states in "initiation, expansion, and improvement of programs and projects....for the education of handicapped children." In 1970, that program was replaced by the *Education of the Handicapped Act* (P.L. 91-230) that, like its predecessor, established a grant program aimed at stimulating States to develop educational programs and resources for individuals with disabilities. Neither program included any specific mandates on the use of the funds provided by the grants; nor could either program be shown to have significantly improved the education of children with disabilities."2

Again, with the drive to be free of discrimination, the *Rehabilitation Act of 1973* was the first of its kind, whereby Section 504 of this the Act prohibited discrimination on the basis of disability. Additionally, the provisions were enforceable in court.

Despite the decisions of the United States Supreme Court and the equal rights momentum demonstrated in historic legislative acts, equal educational rights for students with disabilities did not exist. Public schools in the United States were still essentially closed to children with disabilities. Schools were *not required* to educate or even enroll children with developmental or other disabilities. Across the country court cases showed resistance by the established educational system to allow children with disabilities access to the same educational opportunities as their able-bodied peers. Equal educational rights for students with disabilities were not fully established until 1974, with the passage of PL 94-142, the *Education of All Handicapped Children Act (EAHCA)*. In 1990 EAHCA was renamed the Individuals with Disabilities Education Act (IDEA).

Today, with the weight of history and many pillars to support it, the federal special education law now known as the *Individuals with Disabilities Education and Improvement Act*, or IDEIA, promises millions of American children with disabilities access to a free and appropriate public education. Special education is now not a placement, but a service and children with disabilities, from birth to through 21, are to be guaranteed access to specially designed instruction and related services through the development and implementation of an Individualized Education Program (IEP). It is

intended that no child can legally be denied a free, appropriate, public education based upon his or her disability.

2 *Back to School on Civil Rights*, published by the National Council on Disability (2000)

However, despite real progress made since 1974, significant work remains to be done to ensure that the promise of an "appropriate" education to all students with disabilities is kept. Too many children with disabilities continue to be denied the basic civil right of a meaningful education, frequently receiving services of trivial benefit, facing low expectations, and exclusion from regular classrooms. Congress too has noted these continuing problems and the intent to address in Section 1400 "Findings and Purpose" of the IDEA statute:

> "However, the implementation of this title has been impeded by low expectations, and an insufficient focus on applying replicable research on proven methods of teaching and learning for children with disabilities." "Almost 30 years of research and experience has demonstrated that the education of children with disabilities can be made more effective by... having high expectations for such children... meet developmental goals and, to the maximum extent possible, the challenging expectations that have been established for all children; and be prepared to lead productive and independent lives to the maximum extent possible... strengthening the role and responsibility of parents ... coordinating this title with ... Elementary and Secondary Education Act of 1965"3

It is abundantly clear that the intent from Congress and from the historical recognition of the basic civil right to an education for all children receiving special education services are first and foremost general education children. A disability should not segregate an individual any more than should height, athletic ability, race or religious belief. Despite this basic fact, many (including educators and policy-makers) think of general education and special education as two separate systems and place them in competition with each other for attention and allocation of resources. According to the report by the President's Commission on Special Education, the bureaucratic imperatives of the system are focused on compliance with established procedures rather than academic achievement and this focus fails too many children. 4 In reliance on compliance schools and the courts have often cited the first special education case decided by the U.S. Supreme Court in 1982 based on the 1975 EAHCA known as "Rowley"5 Many Local Education Agencies (LEA's) and judicial opinions still rely on the most minimal standards based on "access to" and "some benefit" from that access that are quoted in the Rowley opinion even though that was based on a time when even allowing children with disabilities to attend a public school was at issue. Some LEA's and the hearing courts have not recognized the intent of moving beyond the most basic "access" and "some benefit" standards to those of providing meaningful education opportunities for future productive and independent adult living as outlined in the language of the current IDEIA.

IDEA is clear in the intent that all children should start their learning in the Least Restrictive Environment (LRE) of general education with the necessary supports and accommodations to make them successful and benefit from their education. The State Council on Developmental Disabilities considers that Schools must do more to ensure that students with disabilities receive a meaningful education based on their individual potential with the same high expectations as for all children. Students with disabilities must be allowed real access to and inclusion in the general curriculum with needed accommodations, modifications and/or supports as well

as access to assistive technology. ~~Schools must concentrate on opening the doors to meaningful inclusion in the community of school for students with disabilities, including~~

~~3 20 U.S.C. 1400(c)(4-5)~~
~~4 "A New Era: Revitalizing Special Education for Children and Their Families", (2002)~~
~~5 Board of Education of Hendrick Hudson Central School District v. Rowley, 1982~~

~~ensuring access to extracurricular activities. Efforts to assist students' transition from school to work or post secondary studies and meaningful access to and inclusion in the daily life of our communities must be enhanced; too many youth with disabilities are still leaving school unprepared for life as adults.~~

~~Special education should be focused on providing those supports and services which allow the closing of the achievement gap between children with disabilities and their typically developing peers. IDEA includes not only the express intent for inclusion and high expectations in the education of children with disabilities but also strengthens the role of parents by full participation as a primary part of the Individualized Education Program (IEP) planning team that decides the appropriate special education supports and services alongside school district staff. To enforce full participation, IDEA includes not only procedural safeguards but also "Due Process" procedures in case of disagreement between team members. In case of disagreement, a Local Education Agency is able to state what it is willing to offer as a Free Appropriate Public Education (FAPE) and the parent may agree or not, then either party desiring a change in the IEP would initiate a due process. According to data from the NCD there are significant issues in the implementation and outcome of special education services that would be expected to result in a large percentage of enforcement cases brought forward to litigation:~~

~~" a deep chasm of opinion on a number of issues particularly relevant to the quality of educational outcomes for students with disabilities. From the students, we hear the reality of their lives in special education. In most cases, the comments we received from them are a scathing indictment of the implementation of IDEA." 6~~

In the State of California approximately 700,000 children receive special education services and supports . IDEA includes not only procedural safeguards but also "Due Process" procedures in case of disagreement between team members. In case of disagreement, a Local Education Agency is able to state what it is willing to offer as a Free Appropriate Public Education (FAPE) and the parent may agree or not, then either party desiring a change in the IEP would initiate a due process.

~~and the "Due Process" is administered by a quasi-judicial state agency known as the Office of Administrative Hearings (OAH, an agency under the executive branch of civil service). During fiscal year 2005-06, approximately 4,012 cases (approximately 0.6%) were filed with the OAH by families who did not agree with the level of supports, services or placement their children received from local school districts (38% of the filings were regarding assessment, while 51% regarded placement). Despite the fact that~~ California has a comprehensive due process procedure in place, however ~~(to appeal decisions of the schools) it appears that families have~~

~~tended not to utilize the system –as reported by families, in part because~~ the system is so difficult to understand and the process appears to favor the ~~agency~~ LEA over the family.
~~Agencies~~ LEAs are more familiar with the system and better able to mount a judicial process
than families of children with disabilities. Advocates report that the inequity of the system
has intimidated many family members of the IEP and in some cases emboldened
~~6 "Individuals With Disabilities Education Act Reauthorization: Where Do We Really Stand", (2002)~~

agency members of the IEP. Family members and advocacy groups have grown increasingly concerned with the apparent inequities of the resolution process and the apperant lack of ~~actual versus required~~ impartiality of the system.~~.~~

PRINCIPLES:

The State Council on Developmental Disabilities understands the importance of preparing all students for independent living and engaged and productive participation in the richness of our society. The State Council on Developmental Disabilities promotes implementation of high quality special education programs as an integral part of the general education community with transparent and impartial monitoring by the following actions:

1. ~~As driven by the weight of history and legislative action, special education is a fundamental civil right, an integral part of the general education program, and a legal mandate. With values such as integration and inclusion replacing inequality and segregation, public education is a means to achieve social participation, productivity, and greater self-reliance leading to independent living to the maximum extent possible. Therefore, t~~The State Council on Developmental Disabilities supports the strengthening or expansion of existing programs and/or creation of new programs to advocate for the right of all students with disabilities to receive a meaningful and free, appropriate, public education in their LRE. Further, to improve upon outcomes leading to independent living to the maximum extent possible, the State Council on Developmental Disabilities supports early and continuous opportunities and actions to improve the transition from high school to adulthood.

2. ~~With the scarcity of resources, some attitudes are expressed that reflect a belief thatspecial education funding and resourcing usurps, or encroaches upon, resources that should go to general education programs (termed encroachment). Because such ideology discriminates against students with disabilities, t~~The State Council on Developmental Disabilities promotes the civil rights of students with disabilities to be free of educational discrimination. The State Council on Developmental Disabilities will endeavor to promote and partner with others to promote public outreach and education activities that

reflect the values that students receiving special education services are part of the general education population and an integral part of their community.

3. ~~Many families have reported extreme difficulty and experienced gaps in services during the transition from early intervention services (Part C services) to special education (Part B services) at age 3. Additionally, much research has been done that demonstrates the importance of children with disabilities receiving services during this critical period of neurodevelopment. A previous safeguard during this transition allowed children to continue receiving the services families had agreed to while attempting to resolve any disagreements in due process. However, that safeguard, termed "Stay Put", was lost for this transition period.~~ The State Council supports the research that has established the importance of early intervention services for children under the age of 3. Therefore, the State Council on Developmental Disabilities supports the return of the "Stay Put" provision in early intervention services (part C of IDEA) to Special Education services (Part B of IDEA) so that there is no gap between the necessary services. ~~this provision, as well as other provisions, that level the playing field between students with disabilities and schools.~~

4. ~~4As evidenced by the large percentage of appeals cases surrounding assessment and placement, many families have reported that IEP's are built on low expectations and that school staff undervalue or ignore their input regarding their children's ability and potential.~~ The State Council on Developmental Disabilities supports the use of assessments and systems that allow for effective identification of students who may be eligible to receive special education, effective assessments of individual needs, which include objective standardized assessments that are supplemented by parental input and other observational data. The Council supports the development of IEP goals that are accurately and appropriately based upon students' abilities and their developmental potential. The Council also supports schools maintaining high expectations that conform, to the maximum extent possible, as close to the California Department of Education's content standards and age appropriate developmental criteria.

~~5.In order to accurately assess the short- and long-term progress of students, the State Council on Developmental Disabilities supports annual and long-term tracking of the progress of students with IEPs relative to standardized norms and to the general student population of their school community. Such tracking will assist schools and students in mutually monitoring their accountability to each other.~~

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~~6.~~5. In following federal and California legal mandates, the State Council on Developmental Disabilities supports the identification and usage of peer reviewed, researched based methodologies to develop instructional strategies, services, and supports for IEPs as measured by implementation outcomes.

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7.6. ~~The operational effect of the law is the interplay of legislation, regulations developed by state and federal agencies, and case law created in courts. Because some issues may require clarification and/or update and because of this interplay, t~~The State Council on Developmental Disabilities promotes education in support of legislative activities that clarify the intent and limitations behind out-of-date case law, legislation, and/or regulations.

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8.7. ~~To better measure the needs, frustrations, and satisfaction of families of children with developmental disabilities, t~~The State Council on Developmental Disabilities supports the use of surveys regarding satisfaction with IDEA implementation by state and local educational agencies including but not limited to: the assessment of children, the identification of the appropriate services and supports to address needs, the definition of goals, objectives and the measurement of progress, the resolution, due process and appeals procedures, and other issues as appropriate. (do you mean Parental survey or do you really want surveys from state and LEA/s if Parental than say Parental surveys regarding...)

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8. ~~Because of lack of clarity and concerns with how public funding is used by schools, the State Council on Developmental Disabilities supports the development of standards which promote the transparency of reporting on the use of public resources for purposes which include but are not limited to the funding special education receives as a percentage of total gross funding, funding devoted to each service and support by category, and cumulative annual and segregate case legal fees paid by each school district to attorneys.~~

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Do you really want to know just how little Sp Ed is funded or do you want to know how the districts are spending monies given to them for Sp Ed., I don't think you will like the percentages and it will do nothing to support the cause of stopping the "encroachment" language? I suggest the following statement:

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The State Council on Developmental Disabilities supports the efforts of the State and LEAs, along with families, to encourage funding of IDEA to the permissive amount originally suggested by congress as up to 40% of the cost. The Council also supports transparency in the usage of Special Education funds received by LEAs.

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10.9. ~~In order to be effective in achieving the above actions and further advocacy on behalf of children with disabilities and their families, t~~The State Council on Developmental Disabilities supports working with other advocacy groups through , local, state, and federal partnerships to coordinate actions, advocate for resources and identify areas of improvement related to special education.

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JAguilar review and recommended edits of changes proposed by MBarraza

POLICY 2010-01: ON SPECIAL EDUCATION

Adopted 2010-03-16 : Last Amended - NA -

BACKGROUND:

The right of every individual to receive a meaningful education is a basic civil right that is well established in the records of our country ~~and by international agreements~~. It is in the interest of the general welfare that all the citizens of our country be educated so as to be better equipped to be productive members of their community and better contribute to society. The ~~equal protection clause of the~~ Fourteenth Amendment to the U.S. Constitution requires states ~~to~~ provide equal protection under the law to all citizens of the United States. ~~Even with states steeped in the mandate under the Fourteenth Amendment, it was not until 1954, when~~ In 1954 the U.S. Supreme Court ~~decided~~ ruled in *Brown versus Board of Education of Topeka*, ~~in which the Court held~~ that education "is a right which must be made available to all on equal terms". In recognition that equal education for all was a civil rights issue the Court wrote:

> "Today, education is perhaps the most important function of state and local governments. Compulsory school attendance laws and the great expenditures for education both demonstrate our recognition of the importance of education to our democratic society. It is the very foundation of good citizenship. Today, it is a principal instrument in awakening the child to cultural values, in preparing him for later professional training, and in helping him adjust normally to his environment. In these days, it is doubtful that any child may reasonably be expected to succeed in life if he is denied the opportunity of an education. Such opportunity, where the state has undertaken to provide it, is a right that must be made available to all on equal terms."[1]

~~In the international forum, the United Nations General Assembly enshrined the right of every individual to receive an education in the *1948 Universal Declaration of Human Rights* and in a renewing pledge made by the world community at the *1990 World Conference on Education for All* to ensure the right to a meaningful education for all regardless of individual differences.~~

In 1964 Congress passed the *Civil Rights Act of 1964*. This historic legislation not only encouraged the desegregation of public schools, but it also barred discrimination on the basis of race, religion, gender, or ethnicity. Providing a broad framework to advocate for equal rights to access public resources, the Act also laid the foundation for special education.

~~Following on the heels of the *Civil Rights Act of 1964*, in~~In 1965 Congress enacted the *Elementary and Secondary Education Act* (ESEA) to address the inequality of educational opportunity for many underprivileged children. This landmark legislation provided a foundation to help ensure disadvantaged students had access to quality education. In 1966 Congress acted quickly in amending ESEA to encourage

[1] *Brown v. Board of Education*, 347 U.S. 483 (1954)

improvement in the education of children with disabilities[2]. ~~The National Council on Disability (NCD), an independent federal agency, noted:~~

> ~~"Congress first addressed the education of students with disabilities in 1966 when it amended the *Elementary and Secondary Education Act of 1965* to establish a grant program to assist states in "initiation, expansion, and improvement of programs and projects....for the education of handicapped children." In 1970, that program was replaced by the *Education of the Handicapped Act* (P.L. 91-230) that, like its predecessor, established a grant program aimed at stimulating States to develop educational programs and resources for individuals with disabilities. Neither program included any specific mandates on the use of the funds provided by the grants; nor could either program be shown to have significantly improved the education of children with disabilities."[3]~~

~~Again, with the drive to be free of discrimination, the~~The *Rehabilitation Act of 1973* was the first of its kind, whereby Section 504 of ~~this~~ the Act prohibited discrimination on the basis of disability. ~~Additionally, the provisions were enforceable in court.~~

~~Despite the decisions of the United States Supreme Court and the equal rights momentum demonstrated in historic legislative acts, equal educational rights for students with disabilities did not exist. Public schools in the United States were still essentially closed to children with disabilities. Schools were **not required** to educate or even enroll children with developmental or other disabilities. Across the country court cases showed resistance by the established educational system to allow children with disabilities access to the same educational opportunities as their able-bodied peers.~~ Equal educational rights for students with disabilities were not fully established until 1974, with the passage of PL 94-142, the *Education of All Handicapped Children Act (EAHCA)*[4]. In 1990 EAHCA was renamed the Individuals with Disabilities Education Act (IDEA).

~~Today, with the weight of history and many pillars to support it,~~In 2004 the federal special education law ~~now known as~~was renamed the *Individuals with Disabilities Education and Improvement Act*, or IDEIA, promises millions of American children with disabilities access to a free and appropriate public education. Special education is now not a placement, but a service and children with disabilities, from birth ~~to~~ through age 21, are to be guaranteed access to specially designed instruction and related services through the development and implementation of an Individualized Education Program (IEP). It is intended that no child can legally be denied a free, appropriate, public education based upon his or her disability.

However, ~~despite real progress made since 1974, s~~ignificant work remains to be done to ensure that the promise of an "appropriate" education to all students with disabilities is kept. Too many children with disabilities continue to be denied the basic civil right of

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[2] For additional information see "*Back to School on Civil Rights*", published by the National Council on Disability (2000)

[3] ~~*Back to School on Civil Rights*, published by the National Council on Disability (2000)~~

[4] Prior to this Act schools were ***not required*** to educate or even enroll children with developmental or other disabilities and there was widespread resistance by the established educational system to allow children with disabilities access to the same educational opportunities as their able-bodied peers

a meaningful education, frequently receiving services of trivial benefit, facing low expectations, and exclusion from regular classrooms. Congress too has noted these continuing problems and the intent to address in Section 1400 "Findings and Purpose" of the IDEA statute:

> "However, the implementation of this title has been impeded by low expectations, and an insufficient focus on applying replicable research on proven methods of teaching and learning for children with disabilities." "Almost 30 years of research and experience has demonstrated that the education of children with disabilities can be made more effective by... having high expectations for such children... meet developmental goals and, to the maximum extent possible, the challenging expectations that have been established for all children; and be prepared to lead productive and independent lives to the maximum extent possible... strengthening the role and responsibility of parents ... coordinating this title with ... Elementary and Secondary Education Act of 1965"[5]

~~It is abundantly clear that the intent from Congress and from the historical recognition of the basic civil right to an education for all children receiving special education services are first and foremost general education children. A~~ Education is a basic civil right for all children and a disability should not be the cause to deny that right or to segregate an individual ~~any more than should height, athletic ability, race or religious belief~~. Despite this basic fact, many ~~(including educators and policy makers)~~ think of general education and special education as two separate segregated systems and even place them in competition with each other for attention and allocation of resources. Children receiving Special Education services are a contributing part of the general education body and not a separate or competing body. ~~According to the report by the President's Commission on Special Education, the bureaucratic imperatives of the system are focused on compliance with established procedures~~Furthermore, many administrators see the focus of Special Education as compliance with procedures rather than academic achievement and this focus fails too many children. [6] In reliance on compliance schools and the courts have often cited the first special education case decided by the U.S. Supreme Court ~~in 1982 based on the 1975 EAHCA~~ known as "Rowley"[7] Many Local Education Agencies (LEA's) and judicial opinions still rely on the most minimal standards based on "access to" and "some benefit" from that access that are quoted in the Rowley opinion even though that was based on a time when even allowing children with disabilities to attend a public school was at issue. Some LEA's and ~~the hearing~~ courts have not recognized the intent of moving beyond the most basic "access" and "some benefit" standards to those of providing meaningful education opportunities for future productive and independent adult living as outlined in the language of the current IDEIA.

IDEA is clear in the intent that all children should start their learning with their peers in the Least Restrictive Environment (LRE) of general education with the necessary supports and accommodations to make them successful and benefit from their education. The State Council on Developmental Disabilities considers that ~~S~~schools must do more to ensure that students with disabilities receive a meaningful education

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[5] *20 U.S.C. 1400(c)(4-5)*

[6] *"A New Era: Revitalizing Special Education for Children and Their Families", (2002), Presidents Commission on Special Education*

[7] *Board of Education of Hendrick Hudson Central School District v. Rowley, 1982 case decided on 1975 EAHCA language*

based on their individual potential with the same high expectations as for all children. Students with disabilities must be allowed real access to and inclusion in the general curriculum with needed accommodations, modifications and/or supports as well as access to assistive technology. Schools must concentrate on opening the doors to meaningful inclusion ~~in the community of school~~ for students with disabilities, including ensuring access to extracurricular activities. Efforts to assist students' transition from school to work or post-secondary studies and meaningful access to and inclusion in the daily life of our communities must be enhanced; too many youth with disabilities are still leaving school unprepared for life as adults.

Special education should be focused on ~~providing those supports and services which allow the~~ closing of the achievement gap between children with disabilities and their typically developing peers. IDEA includes not only the express intent for inclusion and high expectations in the education of children with disabilities but also strengthens the role of parents by full participation as a primary part of the Individualized Education Program (IEP) planning team ~~that decides the appropriate special education supports and services alongside school district staff~~. ~~To enforce full participation, IDEA includes not only procedural safeguards but also "Due Process" procedures in case of disagreement between team members. In case of disagreement, a Local Education Agency is able to state what it is willing to offer as a Free Appropriate Public Education (FAPE) and the parent may agree or not, then either party desiring a change in the IEP would initiate a due process~~IDEA includes not only procedural safeguards but also "Due Process" procedures in case of disagreement between team members. In case of disagreement, an LEA may state what it considers to be and is willing to offer as a Free Appropriate Public Education (FAPE) and the parents may agree or not, if disagreement persists either party may initiate a due process hearing. According to data from the NCD there are significant issues in the implementation and outcome of special education services that would be expected to result in a large percentage of enforcement cases brought forward to litigation:

> "- a deep chasm of opinion on a number of issues particularly relevant to the quality of educational outcomes for students with disabilities. From the students, we hear the reality of their lives in special education. In most cases, the comments we received from them are a scathing indictment of the implementation of IDEA." [8]

In the State of California approximately 700,000 children receive special education services and supports and the "Due Process" is administered by a quasi-judicial state agency known as the Office of Administrative Hearings (OAH, an agency under the executive branch of civil service). ~~During fiscal year 2005-06, approximately 4,012 cases (approximately 0.6%) were filed with the OAH by families who did not agree with the level of supports, services or placement their children received from local school districts (38% of the filings were regarding assessment, while 51% regarded placement). Despite the fact that~~ California has a comprehensive due process procedure in place, however ~~(to appeal decisions of the schools) it appears that~~ families have tended not to utilize the system ~~as reported by families, in part~~ because the system is ~~so~~ difficult to understand and the process appears to favor the LEA~~agency~~ over the family. ~~Agencies~~ LEAs are more familiar with the system and better able to mount a judicial process than families of children with disabilities. Many families with

[8] "*Individuals With Disabilities Education Act Reauthorization: Where Do We Really Stand", (2002)*

children that have disabilities struggle financially and are stretched to maintain the stability of the home environment. The Local Educational Agency has employees and legal resources paid by public funds to mount a "Due Process" litigation whereas the family must rely on the limited time and resources of the parents. ~~Additionally, because of the complexity and odds of the process, families are unable to find free and/or low cost representation in most cases.~~ It is commonly understood by both families and agency representatives that "it is not an even playing field". Advocates report that the inequity of the system has intimidated many family members of the IEP and in some cases emboldened agency members of the IEP. Family members and advocacy groups have grown increasingly concerned with the apparent inequities of the resolution process and ~~the actual versus required~~apparent lack of impartiality of the system.

PRINCIPLES:

The State Council on Developmental Disabilities understands the importance of preparing all students for independent living and engaged and productive participation in the richness of our society. The State Council on Developmental Disabilities promotes implementation of high quality special education programs as an integral part of the general education community with transparent and impartial monitoring by the following actions:

1. ~~As driven by the weight of history and legislative action, special e~~Education is a fundamental civil right~~, an integral part of the general education program, and a legal mandate. With values such as integration and inclusion replacing inequality and segregation, public education is~~and a means to achieve social participation, productivity, and greater self-reliance leading to independent living to the maximum extent possible. ~~Therefore, t~~The State Council on Developmental Disabilities supports the strengthening or expansion of existing programs and/or creation of new programs to advocate for the right of all students with disabilities to receive a meaningful and free, appropriate, public education in their Least Restrictive Environment. Further, to improve upon outcomes leading to independent living to the maximum extent possible, the State Council on Developmental Disabilities supports early and continuous opportunities and actions to improve the transition from high school to adulthood.

2. ~~With the scarcity of resources, some~~Often discriminatory attitudes are expressed that cast Special Education as separate from and in competition with ~~reflect a belief that special education funding and resourcing usurps, or encroaches upon, resources that should go to~~ general education programs (this separation and competition is termed encroachment). Because such ideology discriminates against students with disabilities, the State Council on Developmental Disabilities promotes the civil rights of students with disabilities to be free of educational discrimination. The State Council on Developmental Disabilities will promote and partner with others to promote public outreach and education activities that reflect the values that students receiving special education services are not an encroachment on but an integral part of the general education population and ~~an integral part of~~ their community.

3. ~~Many families have reported extreme difficulty and experienced gaps in services during the transition from early intervention services (Part C services) to special education (Part B services) at age 3. Additionally, much research has been done that demonstrates the importance of children with disabilities receiving services~~

~~during this critical period of neurodevelopment. A previous safeguard during this transition allowed children to continue receiving the services families had agreed to while attempting to resolve any disagreements in due process. However, that safeguard, termed "Stay Put", was lost for this transition period.~~ The State Council supports the research that has established the importance of early intervention services for children under the age of 3. **Therefore, the State Council on Developmental Disabilities supports the return of** ~~this provision, as well as other provisions, that level the playing field between students with disabilities and schools~~the "Stay Put" provision in early intervention services (Part C of IDEA) to Special Education services (Part B of IDEA) so that there is no gap between the necessary services.

4. As evidenced by the large percentage of appeals cases surrounding assessment and placement, many families have reported that IEP's are built on low expectations and that school staff undervalue or ignore their input regarding their children's ability and potential. The State Council on Developmental Disabilities supports the use of assessments and systems that allow for effective identification of students who may be eligible to receive special education, effective assessments of individual needs, which include objective standardized assessments that are supplemented by parental input and other observational data. The Council supports the development of IEP goals that are accurately and appropriately based upon students' abilities and their developmental potential. The Council also supports schools maintaining high expectations that conform, to the maximum extent possible, as close to the California Department of Education's content standards and age appropriate developmental criteria.

5. In order to accurately assess the short- and long-term progress of students, the State Council on Developmental Disabilities supports annual and long term tracking of the progress of students with IEPs relative to standardized norms and to the general student population of their school community. Such tracking will assist schools and students in mutually monitoring their accountability to each other.

6. In following federal and California legal mandates, the State Council on Developmental Disabilities supports the identification and usage of peer reviewed, researched based methodologies to develop instructional strategies, services, and supports for IEPs as measured by implementation outcomes.

7. The ~~operational effect of the law is the interplay of legislation, regulations developed by state and federal agencies, and case law created in courts. Because some issues may require clarification and/or update and because of this interplay, the~~ State Council on Developmental Disabilities promotes education in support of legislative activities that clarify the intent and limitations behind out-of-date case law, legislation, and/or regulations.

8. ~~To better measure the needs, frustrations, and satisfaction of families of children with developmental disabilities, t~~The State Council on Developmental Disabilities supports the use of family/parental surveys regarding satisfaction with IDEA implementation by state and local educational agencies including but not limited to: the assessment of children, the identification of the appropriate services and supports to address needs, the definition of goals, objectives and the measurement of progress, the resolution, due process and appeals procedures, and other issues as appropriate.

9. Because of lack of clarity and concerns with how public funding is used by schools, the State Council on Developmental Disabilities supports the development of standards which promote the transparency of reporting on the use of public resources for purposes which include but are not limited to the funding special education receives as a percentage of total gross funding, funding devoted to each service and support by category, and cumulative annual and segregate case legal fees paid by each school district to attorneys.

10. ~~In order to be effective in achieving the above actions and further advocacy on behalf of children with disabilities and their families, the~~ The State Council on Developmental Disabilities supports working with other advocacy groups through, local, state and federal partnerships to coordinate actions, advocate for resources and identify areas of improvement related to special education.

Risley, Carol@SCDD

From: scdd-efc@yahoogroups.com on behalf of ergelber@sbcglobal.net [eric.gelber@asm.ca.gov]
Sent: Thursday, February 03, 2011 4:49 PM
To: scdd-efc@yahoogroups.com
Subject: [scdd-efc] AB 254 (Beall) - Employment First Policy

I want to let you know that a new bill was introduced today--AB 254 (Beall)--related to the Employment First Policy. But please note: THIS IS A PLACEHOLDER, 2-YEAR BILL and won't be heard until next year. It was introduced to provide a vehicle to implement proposals and recommendations from the Employment First Committee following the issuance of the first annual Report, in July. (The current language, which may or may not remain as the bill is amended, is from earlier versions of AB 287.) We can work on amended bill language over the summer and fall based on the recommendations of the Committee. The bill will be heard in its first policy committee next January. We anticipate that there will be additional bills introduced next year (and in future years) related to the Employment First Policy.

I look forward to continuing to work with you to increase integrated employment opportunities for people with developmental disabilities.

Eric

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449

ASSEMBLY BILL No. 254

Introduced by Assembly Member Beall

February 3, 2011

An act to amend Section 4646.5 of, and to add Section 4869 to, the Welfare and Institutions Code, relating to developmental services.

LEGISLATIVE COUNSEL'S DIGEST

AB 254, as introduced, Beall. Developmental services: Employment First Policy.

The Lanterman Developmental Disabilities Services Act authorizes the State Department of Developmental Services to contract with regional centers to provide support and services to individuals with developmental disabilities. The services and supports to be provided to a regional center consumer are contained in an individual program plan (IPP), developed in accordance with prescribed requirements.

Existing law requires the State Council on Developmental Disabilities to form a standing Employment First Committee to identify strategies and recommend legislative, regulatory, and policy changes to increase integrated employment for persons with developmental disabilities, as specified.

This bill would require the regional center, when developing an individual program plan for a transition age youth or working age adult, to be guided by the Employment First Policy. The bill also, beginning when a consumer is 14 years of age, would require the planning team to discuss school-to-work opportunities during individual program plan meetings and to inform the consumer, parent, legal guardian, or conservator that the regional center is available, upon request, to participate in the consumer's individualized education plan meetings

to discuss transition planning. The bill would require the planning team, as part of the individual program plan process for working age adults, to address integrated employment opportunities, while respecting the consumer's right to choose.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 4646.5 of the Welfare and Institutions Code is amended to read:

4646.5. (a) The planning process for the individual program plan described in Section 4646 shall include all of the following:

(1) Gathering information and conducting assessments to determine the life goals, capabilities and strengths, preferences, barriers, and concerns or problems of the person with developmental disabilities. For children with developmental disabilities, this process should include a review of the strengths, preferences, and needs of the child and the family unit as a whole. Assessments shall be conducted by qualified individuals and performed in natural environments whenever possible. Information shall be taken from the consumer, his or her parents and other family members, his or her friends, advocates, providers of services and supports, and other agencies. The assessment process shall reflect awareness of, and sensitivity to, the lifestyle and cultural background of the consumer and the family.

(2) A statement of goals, based on the needs, preferences, and life choices of the individual with developmental disabilities, and a statement of specific, time-limited objectives for implementing the person's goals and addressing his or her needs. These objectives shall be stated in terms that allow measurement of progress or monitoring of service delivery. These goals and objectives should maximize opportunities for the consumer to develop relationships, be part of community life in the areas of community participation, housing, work, school, and leisure, increase control over his or her life, acquire increasingly positive roles in community life, and develop competencies to help accomplish these goals.

(3) When developing individual program plans for children, regional centers shall be guided by the principles, process, and services and support parameters set forth in Section 4685.

(4) When developing an individual program plan for a transition age youth or working age adult, the regional center shall be guided by the Employment First Policy described in Chapter 14 (commencing with Section 4868). Beginning when a consumer is 14 years of age, the planning team shall discuss school-to-work opportunities during individual program plan meetings, and the regional center representative shall inform the consumer, parent, legal guardian, or conservator that the regional center is available, upon request, to participate in the consumer's individualized education plan meetings to discuss transition planning.

~~(4)~~

(5) A schedule of the type and amount of services and supports to be purchased by the regional center or obtained from generic agencies or other resources in order to achieve the individual program plan goals and objectives, and identification of the provider or providers of service responsible for attaining each objective, including, but not limited to, vendors, contracted providers, generic service agencies, and natural supports. The plan shall specify the approximate scheduled start date for services and supports and shall contain timelines for actions necessary to begin services and supports, including generic services.

~~(5)~~

(6) When agreed to by the consumer, the parents or legally appointed guardian of a minor consumer, or the legally appointed conservator of an adult consumer or the authorized representative, including those appointed pursuant to subdivision (d) of Section 4548 and subdivision (e) of Section 4705, a review of the general health status of the adult or child including a medical, dental, and mental health needs shall be conducted. This review shall include a discussion of current medications, any observed side effects, and the date of last review of the medication. Service providers shall cooperate with the planning team to provide any information necessary to complete the health status review. If any concerns are noted during the review, referrals shall be made to regional center clinicians or to the consumer's physician, as appropriate. Documentation of health status and referrals shall be made in the consumer's record by the service coordinator.

~~(6)~~

(7) A schedule of regular periodic review and reevaluation to ascertain that planned services have been provided, that objectives

have been fulfilled within the times specified, and that consumers and families are satisfied with the individual program plan and its implementation.

(b) For all active cases, individual program plans shall be reviewed and modified by the planning team, through the process described in Section 4646, as necessary, in response to the person's achievement or changing needs, and no less often than once every three years. If the consumer or, where appropriate, the consumer's parents, legal guardian, or conservator requests an individual program plan review, the individual program shall be reviewed within 30 days after the request is submitted.

(c) (1) The department, with the participation of representatives of a statewide consumer organization, the Association of Regional Center Agencies, an organized labor organization representing service coordination staff, and the Organization of Area Boards shall prepare training material and a standard format and instructions for the preparation of individual program plans, which embodies an approach centered on the person and family.

(2) Each regional center shall use the training materials and format prepared by the department pursuant to paragraph (1).

(3) The department shall biennially review a random sample of individual program plans at each regional center to assure that these plans are being developed and modified in compliance with Section 4646 and this section.

SEC. 2. Section 4869 is added to the Welfare and Institutions Code, to read:

4869. In furtherance of the Employment First Policy established pursuant to this chapter, the individual program plan process for working age adults shall address integrated employment opportunities, while respecting the consumer's right to choose.

O